OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
March 20, 2024, at 2:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK. 73105

A G E N D A

Public access via Zoom:
https://www.zoomgov.com/webinar/register/WN_ehVFOS6CQkWP_aJk0bxnDQ
Telephone: 1-669-216-1590 Webinar ID: 161 051 2392

*Please note: Since the physical address for the OHCA Board Meeting has resumed, any livestreaming option provided is provided as a courtesy. Should such livestreaming option fail or have technical issues, the OHCA Board Meeting will not be suspended or reconvened because of this failure or technical issue.

1. Call to Order / Determination of Quorum……...Marc Nuttle, Chair

2. Discussion and Vote on the January 17, 2024, OHCA Board Meeting Minutes……..…..…….Marc Nuttle, Chair

3. Chief Executive Officer Report (Attachment "A")…..……..Ellen Buettner, Chief Executive Officer

    a) Member Moment

4. State Medicaid Director Report (Attachment "B")…….……Traylor Rains, State Medicaid Director

5. Chief of Staff Report……Christina Foss, Chief of Staff

6. Discussion of Report from the Pharmacy……..…….Jeff Cruzan, MD
   Advisory Committee and Possible Action Regarding Member, Pharmacy Advisory Committee
   Drug Utilization Review Board Recommendation:

    a) Discussion and Possible Vote on Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.1, § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:2-1-11 (Attachment "C"):

Drug Name:	Used For:
Sohonos™	Fibrodysplasia Ossificans Progressiva
Miebo™ Vevye®	Dye Eye Disease
Veozah™	Vasomotor Symptoms of Menopause
Elrexfio™ Talvey™	Multiple Myeloma
Rystiggo® Zilbrysq® Vyvgart® Hytrulo	Myastenia Gravis
Elfabrio® Opfolda™ Pombiliti™	Fabry Disease Pompe Disease Pompe Disease
Hepzato Kit™	Metastatic Uveal Melanoma

Zynyz™	Merkel Cell Carcinoma
Iwilfin™ Kepivance® Loqtorzi™ Omisirge®	High-Risk Neuroblastoma Oral Mucositis Nasopharyngeal Carcinoma Neutropenia
Ogsiveo™	Desmoid Tumor
Renagel® Xphozah®	Hyperphosphatemia
iDose® TR	Open-Angle Glaucoma

7. Discussion of Report from the Compliance Advisory Committee and Possible Action……..……..……Phillip Kennedy Chair, Compliance Advisory Committee

    a) Discussion and Possible Vote to Approve the State Plan Amendment Rate Committee Rates pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:1-3-4 (Attachment "D")

        i. Per Diem Rate for Freestanding Rehabilitation Hospitals Operated by Units of Government

    b) Discussion and Possible Vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:10-1-16. (Attachment "E")

        i. Medicaid Management Information System
        ii. Asset Verification System Services

8. Discussion of Report of Strategic Planning & Operational Advisory Committee…….Marc Nuttle Chair, Strategic Planning & Operational Advisory Committee

9. Discussion of Report of Administrative Rules Advisory Committee and Possible Action (Attachment "F")……..…Tanya Case Chair, Administrative Rules Advisory Committee

    i. APA WF # 24-03 Collaborative Care Model Reimbursement
    ii. APA WF # 24-04 Hospital Provision of Opioid Antagonist
    iii. APA WF # 24-05 Private Duty Nursing (PDN) Coverage Limitations Change
    iv. APA WF # 24-12 Medication Limits

10. Discussion and Possible Action……Marc Nuttle, Chair
    Possible Executive Session as Recommended by the General Counsel and Authorized by the Open Meeting Act, 25 O.S. § 307(B)(4) , To Discuss Confidential Legal Matters Concerning Pending Litigation

11. Adjournment…….Marc Nuttle, Chair

NEXT BOARD MEETING
May 15, 2024, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

MINUTES OF REGULAR BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 17, 2024
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on January 16, 2024 at 2:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on January 12, 2023 at 10:31 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Nuttle called the meeting to order at 2:01 p.m.

BOARD MEMBERS PRESENT: Member Case, Member Christ, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Chairman Nuttle (arrived at 2:30pm), Vice-Chairman Yaffe

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON THE DECEMBER 7, 2023, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Jolley moved for approval of the December 7, 2023, board meeting minutes, as published. The motion was seconded by Member Finch.

BOARD MEMBERS PRESENT: Member Case, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland

ABSTAINED: Member Christ

BOARD MEMBERS ABSENT: Chairman Nuttle, Vice-Chairman Yaffe

ITEM 3 / CHIEF EXECUTIVE OFFICER REPORT
Ellen Buettner, Chief Executive Officer

CEO Buettner invited Carolyn Reconnu-Shoffner to provide a member moment.

CEO Buettner highlighted Empowerment and Accountability, which is one of OHCA's Key Principles, while also highlighting the Eligibility and Coverage team.

Key Initiatives:

- SoonerSelect & PHE – SoonerSelect Dental open enrollment and auto-assignment and onsite readiness reviews have been completed. Dental will go-live on February 1st. Medical open enrollment will also begin on February 1st. As of today, five of the seven Directed Payment Preprints have been approved by CMS. As for PHE, OHCA has also submitted its final report to CMS. A postmortem report will be provided at an upcoming board meeting.

- Administrative – Jennifer Lamb-Hornsby and her team have been completing "stay" and "boomerang" interviews. Over the last 60-days, the team observed that employees that have left the agency to pursue different opportunities or were enticed by the plans have since returned. The Org Development team has also been working on Korn Ferry Competencies, which is an employee development and performance management framework that aligns OHCA's business strategy with individual goals. In line with that, a new mentoring program has been created and currently has 5 staff members enrolled. The Administrative Services team continues to make progress with the building move. Construction will start in mid-February. OHCA employees have competed their move to the first floor and the Department of Corrections have completed their move to the second floor. Lastly, CEO Buettner stated that budget hearings have competed. The Senate hearing look place last week, while the House hearing took place this morning.

- Traction – CEO Buettner highlighted SoonerRide and program improvements. The SoonerRide team and Communications have been engaging with other to understand what the challenges are and how best to address them. The team continue to build the network to address the challenges. ModivCare's Network Optimization team was on the ground recruiting providers. As a result of that, new contracts were implemented with providers in

bordering states. A Joplin-based provider will provide services for the Northeastern part of Oklahoma and a Dallas-based provider will provide services for the Southeastern part of Oklahoma. A high-performing Texas provider has also been contracted and agreed to bring 10 new wheelchair vehicles to Oklahoma this year. The team has also amended current contracts to allow taxis to provide these services.

Stakeholder Engagement – CEO Buettner highlighted previous and upcoming meetings and presentations. CEO Buettner stated that she traveled to DC in December to meet with Oklahoma Federal Delegation. The discussions centered primarily around PHE status and the SoonerSelect transition. Similar conversations have taken place with CMS, who has been very complimentary of the OHCA team, and the National Governor's Association.

For more detailed information, see attachment "A" of the board packet.

ITEM 4 / STATE MEDICAID DIRECTOR REPORT
Traylor Rains, State Medicaid Director

Mr. Rains provided a State Medicaid Director Update, which included information on Public Health Emergency Unwinding, SoonerSelect Milestones Achieved, Important Dental Milestones, Important Medical and Children Specialty Program Milestones, and SoonerCare Operations Update.

For more detailed information, see attachment "B" of the board packet.

ITEM 5 / CHIEF OF STAFF REPORT
Christina Foss, Chief of Staff

Ms. Foss provided a brief update on communication efforts surrounding SoonerSelect and OHCA's legislative priorities.

Communications – The team is working on ensuring that appropriate communication is being sent to members, providers, community partners, and ensuring that the message is clear. The team has focused on day-one communication and what that looks like. The team have also been partnering with agency and community partners to host different events like the upcoming OU Health wellness benefit fairs where they will feature the plans. To ensure consistency, the plans send all their outreach materials to OHCA prior to sending out to potential members.

Legislative Priorities – This session, OHCA has four request bills:

SB 1417 Nursing Facility Reimbursement Methodology: This would keep the base rate for Nursing Facilities, but the add-on rates would be centered around quality metrics and acuity residents in the facility.

SB 1419 Paid Family Caregiver: For kids that qualify for PDN services, that may have had hours reduced, OHCA is looking at allowing a new provider type which would allow parents to become reimbursed, after they go through training and receive proper certification.

SB 1420 ABA Services: This bill is currently listed in the FY25 budget request. It would expand ABA services to those with an IDD diagnosis.

SB 1703 Third Party Liability: This was a provision that was passed in the Consolidated Appropriations Act in 2022. This bill would add a provision that Third Party payers are barred from refusing payment for an item or service solely on the bases that the service did not receive a prior authorization under the third-party payers' rule.

ITEM 6 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phillip Kennedy, Chair, Compliance Advisory Committee

Member Kennedy provided the Compliance Committee Update, which included information on OHCA financials, Program Integrity, and presented the State Plan Amendment Rate Committee Brief.

Financials – For the quarter that ended on November 30, 2023, OHCA's revenues were 0.3% over budget while expenditures were 0.5% under budget. This gives the agency a positive budget variance of $27.9 million. Revenues from drug rebates were $55 million over budget and medical refunds were $15 million over budget. All receivables from sister agencies are current as focus continues to focus on timely collection while monitoring cash flow.

Program Integrity Update – OHCA's Payment Accuracy Measurement (PAM) review completed the 2023 medical review during the last quarter. The final error rates were 0.13% and 0.15% for Medicaid/TXIX (Title 19) and CHIP/TXXI (Title 21), respectively. For the second quarter of FY24, Program Integrity closed a total of 172 audits with 134 of those cases having an overpayment. The total identified overpayment for the second quarter was $723,874.08. Audit activities are

ongoing. Clinical Provider Audits currently has 115 open audits and Data Analytics currently has 11 open super cases or audit projects; six are in the analysis phase and the remaining five are active, impacting 132 providers.

a) Discussion and Possible Vote to Approve the State Plan Amendment Rate Committee Rate pursuant to 63 O.S. Section 5006 (A)(2) under OAC 317:1-3-4 (see Attachment "C")

i. State Plan Personal Care Service Rate Increase

MOTION: Member Kennedy moved for approval of item 6ai, as published. The motion was seconded by Jolley.

FOR THE MOTION: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe

ITEM 7 / DISCUSSION OF REPORT OF STRATEGIC PLANNING & OPERATIONAL ADVISORY COMMITTEE
Marc Nuttle, Chair, Strategic Planning & Operational Advisory Committee

Chairman Nuttle introduced Steve Miller, who provided an update on OHCA's 3-year Technology Strategic Plan which included information on Objectives, Usability Engineering, Guiding Principles for IT Solutions, Technology Roadmap, IT Governance Process, Data Driven Culture, Current Medicaid Enterprise System, OHCA Strategic Transformation Roadmap, Business Enterprise/IT Organization Makeup, and HIE Update.

For more detailed information, see attachment "D" of the board packet.

ITEM 8 / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING
Tanya Case, Chair, Administrative Rules Advisory Committee

Discussion and Possible Vote on Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act and in accordance with 75 O.S. § 253. OHCA Requests the Adoption of the Following Emergency Rules (see Attachment "E")

a) The following **EMERGENCY** rules *were* previously adopted by the Board on September 20, 2023, under **EMERGENCY** rulemaking.

i. APA WF 24-07 Secure Mental Health Transportation *(previously APA WF # 23-13)*
ii. APA WF 24-08 Biosimilar Reimbursement *(previously APA WF # 23-15)*
iii. APA WF 24-09 Continuous Eligibility for Children *(previously APA WF # 23-18)*
iv. APA WF 24-10 Non-Payment of Provider Preventable Conditions *(previously APA WF # 23-08)*

MOTION: Member Jolley motioned to approve the declaration of a compelling public interest for the promulgation of the emergency rules in item 8ai-iv. The motion was seconded by Member Leland.

FOR THE MOTION: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe

MOTION: Member Jolley moved to approve the emergency rules listed in item 8ai-iv as published. The motion was seconded by Member Leland.

FOR THE MOTION: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe

b) The following **EMERGENCY** rules *were not* previously adopted under **EMERGENCY** rulemaking and are new to the Board

v. APA WF # 24-01 Opioid Overdose Reversal Agents
vi. APA WF # 24-02 Federally Qualified Health Center (FQHC) Substance Use Disorder (SUD)

Certification Requirements

vii. APA WF # 24-06 Living Choice

MOTION: Member Jolley motioned to approve the declaration of a compelling public interest for the promulgation of the emergency rules in item 8bv-vii. The motion was seconded by Member Cruzan.

FOR THE MOTION: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe

MOTION: Member Jolley moved to approve the emergency rules listed in item 8bv-vii as published. The motion was seconded by Member Cruzan.

FOR THE MOTION: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe

c) The following **PERMANENT** rules *were* previously adopted by the Board and the Governor under EMERGENCY rulemaking. These rules *were* revised for **PERMANENT** rulemaking.

viii. APA WF # 23-06A&B Transition to SoonerSelect
ix. APA WF # 23-20 TEFRA Psychological Evaluations and ICF/IID Level of Care Reevaluations
x. APA WF # 23-09 Update Services Exempt from Copayment

MOTION: Member Jolley moved to approve the permanent rules listed in item 8cviii-x as published. The motion was seconded by Member Leland.

FOR THE MOTION: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe

d) The following **PERMANENT** rules *were* previously adopted by the Board and Governor under **EMERGENCY** rulemaking. These rules *were not* revised for **PERMANENT** rulemaking.

xi. APA WF # 23-01 State Plan Personal Care Services for Expansion Adults, TEFRA Eligible Children and Certain MAGI Populations
xii. APA WF # 23-02 IO ESI Self-Funded Plans
xiii. APA WF # 23-05 SoonerCare Application Timeframe
xiv. APA WF # 23-10 Doula Services
xv. APA WF # 23-11 Private Duty Nursing Reimbursement
xvi. APA WF # 23-12 Intermediate Care Facilities Payment Program
xvii. APA WF # 23-14 Audio-only Telecommunications Health Service Delivery
xviii. APA WF # 23-16A&B Minimum Age for Enrollment into ADvantage Waiver
xix. APA WF # 23-17 Implement Changes to the Health Information Exchange
xx. APA WF # 23-19 Adult Day Health Services Revisions
xxi. APA WF # 23-21 Quarterly Payments for Orthodontic Services

MOTION: Member Jolley moved to approve the permanent rules listed in item 8dxi-xxi as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe

e) The following **PERMANENT** rules *were not* previously adopted and are new to the Board.

xxii. APA WF # 23-24 Prosthetic Hearing Implants & Ocular Prosthetics for Adults
xxiii. APA WF # 23-23 Hospital Services Policy

xxiv. APA WF # 23-22 Streamline Behavioral Health Workforce Credentialing
xxv. APA WF # 23-25A&B ADvantage and State Plan Personal Care Revisions
xxvi. APA WF # 23-26 340b Non-Compliant Providers
xxvii. APA WF # 23-27A&B DDS Updates

MOTION: Member Jolley moved to approve the permanent rules listed in item 8dxii-xxvii as published. The motion was seconded by Chairman Nuttle.

FOR THE MOTION: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe

ITEM 9 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE OHCA GENERAL COUNSEL AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4).
Marc Nuttle, OHCA Board Chairman

OHCA General Counsel, Kara Smith, reported that Executive Session was not needed.

ITEM 10 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

MOTION: Member Jolley moved to adjourn. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Jolley, Member Kennedy, Member Leland.

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe

Meeting adjourned at 3:36 p.m., 1/17/2024

NEXT BOARD MEETING
March 20, 2024
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

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CHIEF EXECUTIVE OFFICER REPORT

Ellen Buettner

March 20, 2024

OHCA KEY PRINCIPLES

PASSION FOR PURPOSE

Our purpose is to facilitate quality health care services regardless of ability to pay and create opportunities for our members to attain healthy outcomes.

EMPOWERMENT & ACCOUNTABILITY

We follow through on commitments and take responsibility for our decisions, prioritizing member needs, fiscal stewardship and respect for others.

TRUST & TRANSPARENCY

We are committed to principles of open government by providing consistent and accurate communication to our members, stakeholders and the public.

BEST IN CLASS & OUTCOME-DRIVEN

We strive each day to find ideas and solutions that will drive positive health outcomes for Oklahoma.

SERVANT LEADERSHIP

We strive to help each member of our team achieve personal and professional success. We lead by example for our co-workers, members and stakeholders.

LEAN SIX SIGMA GREEN BELT PRESENTATIONS

- OHCA Quality Department Dashboard
- Eligibility & Coverage Services Call Time
- Improve Lead Time on Incentive Reporting
- Improve Data Related Intake Process
- Quality Assurance Dental Complaint Process Improvement
- Increasing Adult Medicaid Members' Enrollment in "Getting Ahead Classes"

KEY INITIATIVES – SOONER SELECT

- 12 days to Go-Live for Medical and Children's Specialty Programs; April 1 Celebration
- Directed Payment Approvals
- Ongoing dental implementation + member feedback

KEY INITIATIVES - ADMINISTRATIVE

- Secretary of Health & Mental Health
- Building Updates
- Succession Planning
- Legislative
  - Budget
  - SB 1310 & HB 3508

KEY INITIATIVES - TRACTION

HEALTH OUTCOMES

- Pharmacists as providers
- **Analyze and assess non-MCO members to develop quality measures and implement quality improvement** initiatives.
- Provide member and provider educational material to improve outreach to reduce members diagnosed with HepC.

OPERATIONAL EXCELLENCE

- Identify available baseline data, future measures and data needs.
- Analyze and improve customer experience to identify and implement improvements.
- Assess SoonerRide challenges and opportunities.
- Assess Gold Card PA opportunity for ABD population.

FISCAL RESPONSIBILITY

- Create State Directed Payment Programs
- Administer HIE Connection Fee Program
- Connect MCE/HIE
- Develop Technology Strategic Plan
- MMIS Roadmap
- Peoplesoft Implementation

HIGH-PERFORMING TEAMS

- Create and maintain talent continuity plan for all supervisory positions.
- Establish standardized contract administration program.
- Improve Open Records Act tracking and response process.
- Implement external communications plan for SoonerSelect

STAKEHOLDER ENGAGEMENT

- St. Anthony Behavioral Health
- Countryside Health Services
- GKFF/BEST/ConnectFirst
- Lawton Chamber of Commerce
- OK State Medical Association, OK Osteopathic Association, OK Dental Association
- State legislative meetings
- PHRMA Task Force meeting
- Health & Human Services intercabinet meeting
- SoonerSelect media
- Care Providers of Oklahoma
- Gatesway Foundation

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

MEDICAID DIRECTOR UPDATE

MARCH 20, 2023

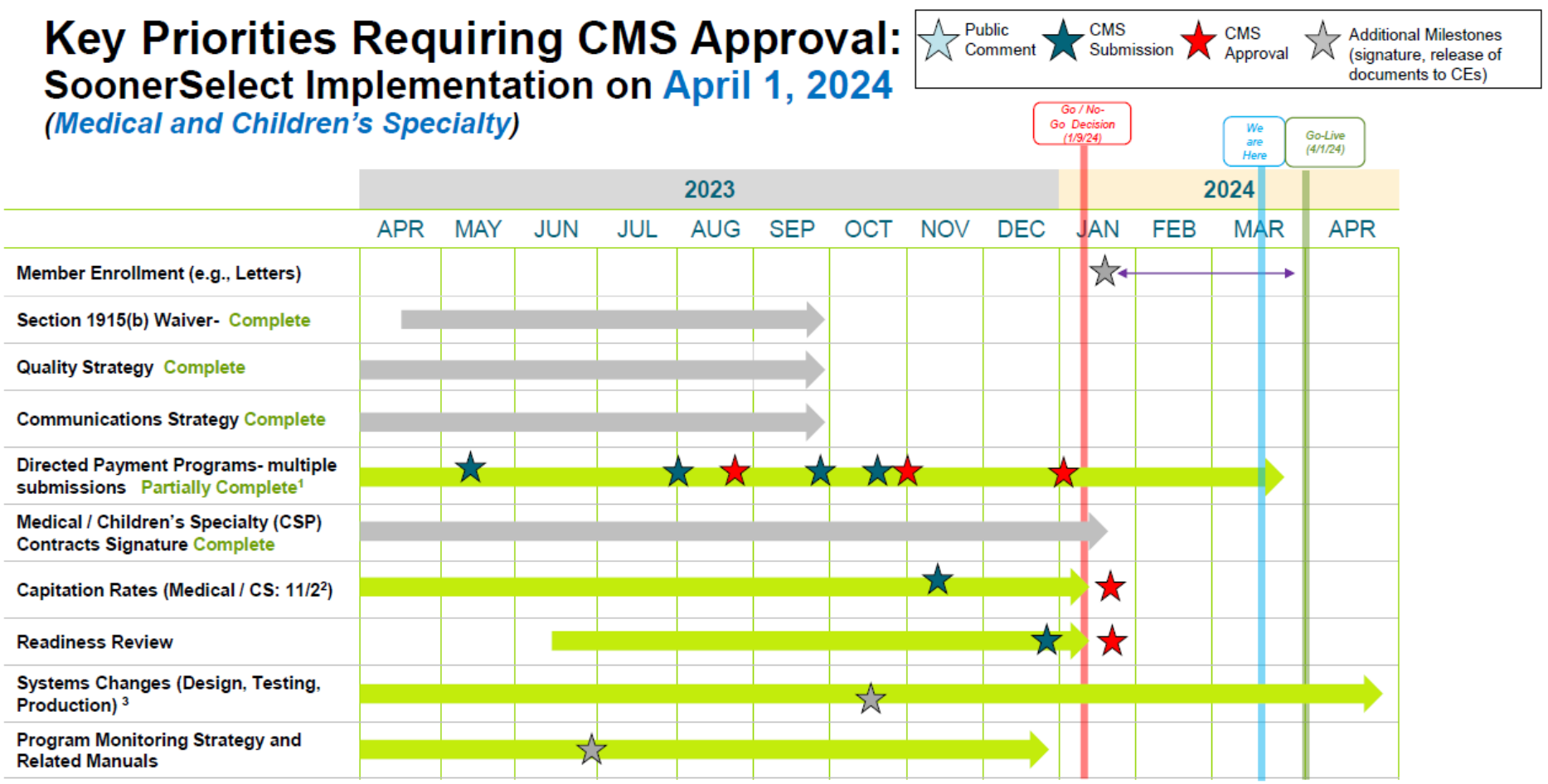
SOONERSELECT UPDATE

MILESTONES ACHIEVED

- SoonerSelect Dental implemented February 1
  - Two dental Contracted Entities (CEs): DentaQuest and LIBERTY Dental
  - During the initial enrollment period (12/1/23-1/10/24), approximately 98,000 members made an active dental plan selection
  - In the initial 90-day continuity of care period, dental CEs are honoring OHCA approved prior authorizations and offering mechanisms for reimbursement of out-of-network providers
  - Informational provider guides have been created and published on the SoonerSelect webpage:
    - SoonerSelect Dental Provider Go-Live Fact Sheet.pdf (oklahoma.gov)
    - SoonerSelect Dental Provider Guide.pdf (oklahoma.gov)
  - OHCA and the dental CES are hosting several joint provider training sessions where providers are learning more about CE-specific processes and asking questions for real-time responses from the dental CEs
- SoonerSelect Medical and Children's Specialty Program will implement on April 1
  - Three medical CEs: Aetna Better Health of Oklahoma, Humana Healthy Horizons, and Oklahoma Complete Health
  - One Children's Specialty Program CE: Oklahoma Complete Health
  - During the initial enrollment period (2/1/24-3/10/24), approximately 114,000 members made an active medical plan selection
  - Auto assignment (used to align members who did not select a plan with a plan) ran on 3/11/2024
  - CEs are beginning to receive enrollment files that identify their membership so that they may begin processes of mailing welcome packets, ID cards, and initiating member outreach
  - Medical and Children's Specialty Program CEs offering multiple opportunities for provider engagement through CE-sponsored town hall events in various statewide locations
  - Informational provider guides are being created for publication prior to go-live

IMPORTANT MILESTONES MEDICAL AND CSP

Key Priorities Requiring CMS Approval:
SoonerSelect Implementation on April 1, 2024
(Medical and Children's Specialty)



PROVIDER SURVEY UPDATE

SoonerCare
PROVIDER SURVEY HIGHLIGHTS | 2023

OHCA conducted a provider survey in 2023 to learn more about providers' experiences and satisfaction with OHCA. The results are helping OHCA **improve service to providers** and **establish baselines for SoonerSelect** contracted entities' service to providers. The survey asked providers questions across eight domains. Providers who responded also gave an overall satisfaction rating and had the opportunity to answer an open-ended question about what OHCA could do to improve service to their practices.

The **CUSTOMER SERVICE** domain contains some of the most consistently satisfied responses across the board.

OHCA is building upon this by improving receptiveness to provider feedback, identifying areas for improvement, tracking OHCA responses and giving this information back to providers.

Dental providers expressed high dissatisfaction with the **DENTAL REIMBURSEMENT RATE**.

The survey was conducted before dental provider rates were increased. OHCA will monitor future provider surveys to measure the impact of the rate increase.

Responses were highly favorable in the areas of **PROVIDER SERVICES STAFF**, **WEBSITE NAVIGATION AND CONTENT**, and ease of use of the **PROVIDER PORTAL**.

OHCA is building upon this by improving receptiveness to provider feedback, identifying areas for improvement, tracking OHCA responses and giving this information back to providers.

PT/OT/ST therapists reported low satisfaction with the **PRIOR AUTHORIZATION SYSTEM** and echoed their frustrations in the open-ended questions.

In July, OHCA began contracting with OU to process these PAs. Since then, the portion of PAs processed in 72 hours or less has improved from lows around 15% to as high as 99%.

Providers expressed an interest in learning more about access to case managers and being more involved with **CARE MANAGEMENT**.

It opens an opportunity to share with providers how case managers can work with members.

SoonerCare Provider Survey Highlights | 2023

Providers were satisfied with the timeliness of **CLAIMS PROCESSING** and reimbursement accuracy.

Customer service for claims processing again showed consistently satisfied responses from providers.

Timeliness of the **CREDENTIALING PROCESS** and the service provided by the SoonerCare credentialing staff received satisfied ratings from licensed medical and behavioral health providers.

OHCA can use the successful credentialing system and adapt to the newest provider groups less familiar with credentialing, such as the doulas and DSME providers.

Medical providers were generally dissatisfied with the **PHARMACY PRIOR AUTHORIZATION SYSTEM**.

Now is an excellent time to explore the pharmacy PA system that SoonerSelect CEs and other payers use.

While no questions in the survey directly addressed **SOONERRIDE**, some expressed frustration with the non-emergency transport and its barriers for some members.

Non-emergency transport will be provided by SoonerSelect CEs, many of which are enhancing the benefit to address some of the barriers. The FY2024 survey will ask specifically about SoonerRide to better understand providers' perspectives

Provider survey has improved OHCA **COMMUNICATION WITH PROVIDERS**.

The survey allowed providers to add direct email addresses for communications. In many cases, OHCA only has the email addresses of credentialing staff.

The survey gives a voice to those who chose to respond, but the results are **not a representative sample** of all providers or individual provider types.

OKLAHOMA
Health Care Authority

WHAT'S ON OUR RADAR?

NEW AND NOTEWORTHY

- Change Healthcare Cyber Attack
  - This event has caused disruption to provider billing clearinghouse operations which has impacted cash flow for many SoonerCare contracted providers.
  - OHCA is working with CMS on ways to assist providers until such time as provider billing systems are fully functioning again.
  - HHS released a statement on March 5.
- State Grant for the Implementation, Enhancement, and Expansion of Medicaid School-Based Services (SBS) Opportunity
  - OHCA is working with the State Department of Education to apply for a funding opportunity through CMS to expand SBS in Oklahoma.
  - Letter of Intent to apply was sent to CMS on February 22.
  - Applications due by March 25th.
  - Estimated maximum award is $2,500,000 per awardee over three years.
- Medicaid Reentry 1115 Demonstration Opportunity
  - CMS initiative that would allow states to cover a package of pre-release services for up to 90 days prior to the individual's expected release date that could not otherwise be covered by Medicaid due to longstanding statutory exclusion that prohibits payment for most services provided in the care of a state or county carceral facility.

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GET IN TOUCH

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Agency: 405-522-7300
Helpline: 800-987-7767

Attachment C

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – December 13, 2023 and February 14, 2024

Vote Item	Drug	Used for	Cost*	Notes
1	Sohonos™	• **Fibrodysplasia Ossificans Progressiva:** FOP is a very rare genetic connective tissue disorder characterized by the abnormal development of bone in areas of the body where bone is not normally present, such as the ligaments, tendons, and skeletal muscles. Specifically, this disorder causes the body's skeletal muscles and soft connective tissues to undergo a metamorphosis, essentially a transformation into bone, progressively locking joints in place and making movement difficult or impossible. *5 members with diagnosis.*	• $383,040 per flare	• First drug approved for treatment of FOP.
2	Miebo™ Vevye®	• **Dye Eye Disease:** Dry eye happens when your eyes don't make enough tears to stay wet, or when your tears don't work correctly. This can make your eyes feel uncomfortable, and in some cases, it can also cause vision problems. *668 members might be eligible*	• $37,008 per year • $5390 per year	• Other cheaper treatment options available without a PA
3	Veozah™	• **Vasomotor Symptoms of Menopause:** VMS, commonly called hot flashes or flushes and night sweats, are the menopausal symptoms for which women seek treatment during menopause most often. *4,140 members with diagnosis.*	• $6,310 per year	• Other cheaper treatment options available without a PA
4	Elrexfio™ Talvey™	• **Multiple Myeloma:** MM is a cancer of plasma cells. In multiple myeloma, the overgrowth of plasma cells in the bone marrow can crowd out normal blood-forming cells, leading to low blood counts. This can cause a shortage of red	• $497,988 per year • $530,691 per year	• Used after 4 previous treatments

		blood cells which can cause a person to feel weak and fatigued. MM can also cause the level of platelets in the blood to become low which can lead to increased bleeding and bruising. Another condition that can develop is a shortage of normal white blood cells which can lead to problems fighting infections. *310 members with diagnosis and might be eligible for treatment*.		
5	Rystiggo® Zilbrysq® Vyvgart® Hytrulo	• **Myastenia Gravis:** MG is an autoimmune chronic neuromuscular disease that causes weakness in the voluntary muscles. *117 members with diagnosis*.	• $363,000 per year • $538,375 per year • $441,644 per year	• Other treatment options should be tried first
6	Elfabrio®	• **Fabry Disease:** FD s an inherited neurological disorder that occurs when the enzyme alpha-galactosidase-A cannot efficiently break down fatty materials known as lipids into smaller components that provide energy to the body When lipids to build up in the system it can lead to harmful levels in the body's autonomic nervous system (the part of the nervous system that controls involuntary functions such as breathing and heartbeat), as well as in the eyes, kidneys, and cardiovascular system. *23 members with diagnosis*.	• $451,557 per year	• Other prior authorized treatment options available
	Opfolda™ Pombiliti™	• **Pompe Disease:** PD is a rare genetic disorder that causes progressive weakness to the heart and skeletal muscles. Without treatment patients can have cardiac and respiratory failure which may lead to death. *12 members with diagnosis*.	• $3,380 per year • $742,560 per year	• Opfolda and Pombiliti are only used together

7	Hepzato Kit™ Zynyz™	• **Metastatic Uveal Melanoma:** MUM is the most common primary intraocular cancer of the eye in adults. Nearly half of primary uveal melanoma tumors metastasize. *5 members with diagnosis.* • **Merkel Cell Carcinoma:** MCC is a rare, aggressive neuroendocrine tumor of the skin. It most frequently presents on the head and neck region of elderly, white males. *7 members with diagnosis.*	• N/A • $185,120 per year	• XXXX • XXXX
8	Iwilfin™ Kepivance® Loqtorzi™ Omisirge®	• **High-Risk Neuroblastoma:** HRNB is a highly aggressive solid tumor that most commonly presents in early childhood. *42 members with diagnosis* • **Oral Mucositis:** OM is probably the most common, debilitating complication of cancer treatments, particularly chemotherapy and radiation. It can lead to several problems, including pain, nutritional problems as a result of inability to eat, and increased risk of infection due to open sores in the mucosa. *Most likely will not see a request.* • **Nasopharyngeal Carcinoma:** NPC is a disease in which malignant cells form in the tissues of the nasopharynx. The nasopharynx is the upper part of the pharynx (throat) behind the nose. *36 members with diagnosis.* • **Neutropenia:** Neutropenia occurs when you have too few neutrophils, a type of white blood cells. *Most likely will not see a request.*	• $259,200 per year • $19,881 per course of treatment • $231,193 per year • $338,000 per dose	• Not first line • Only used in patients undergoing stem cell transplant • Used in combination with other cancer therapies • Only used in patients undergoing stem cell transplant
9	Ogsiveo™	• **Desmoid Tumor:** DTs grow from the connective tissue in the body. DTs can occur	• $347,997 per year	• DTs are most common in people

		anywhere in the body since connective tissue is found everywhere in the body. DTs are often found in the abdomen, as well as the shoulders, upper arms, and thighs. DTs are locally aggressive tumors. *No members with diagnosis. This is rare and seen in 1-2 people per 500,000.*		ages 16 to 60 years old.
10	Renagel® Xphozah®	• **Hyperphosphatemia:** Hyperphosphatemia is a condition in which you have too much phosphate in your blood. Causes include advanced chronic kidney disease, hypoparathyroidism, and metabolic and respiratory acidosis. *2,431 members with diagnosis.*	• $4,060 per year • $35,517 per year	• Cheaper treatment options available • Cheaper treatment options available
11	iDose® TR	• **Open-Angle Glaucoma:** OAG is a chronic, progressive, and irreversible multifactorial optic neuropathy that is characterized by an open angle of the anterior chamber, optic nerve head changes, progressive loss of peripheral vision, followed by central visual field loss. *2,500 members with diagnosis.*	• $13,950 per implant	• Cheaper treatment options available

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. N/A = not available at the time of publication.

Pharmacy Agenda Items

Recommendation 1: Vote to Prior Authorize Sohonos™

The Drug Utilization Review Board recommends the prior authorization Sohonos™ (Palovarotene) with the following criteria:

Sohonos™ (Palovarotene) Approval Criteria:

1. An FDA approved diagnosis of fibrodysplasia ossificans progressiva (FOP); and Diagnosis must be confirmed by genetic testing identifying a pathogenic R206H mutation in the ACVR1 gene (results of genetic testing must be submitted); and
2. Member must be:
    a. 8 years of age or older for female members; or
    b. 10 years of age or older for male members; and
3. For members younger than 14 years of age, member's recent weight (taken within the past 3 weeks) must be provided in order to ensure appropriate dosing in accordance with package labeling; and
4. Must be prescribed by a geneticist or other specialist with expertise in the treatment of FOP; and
5. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test within 1 week prior to therapy initiation; and
6. Prescriber must verify female members of reproductive potential are not breastfeeding and will use effective contraception at least 1 month prior to initiating treatment with Sohonos™ and for 1 month after the last dose of Sohonos™; and
7. Prescriber must verify the member does not have severe renal impairment (creatinine clearance <30mL/min) or moderate or severe hepatic impairment (Child-Pugh B or C); and
8. Member must not be taking any of the following medications concomitantly with Sohonos™:
    a. Strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin); or
    b. Strong or moderate CYP3A4 inducers (e.g., rifampin, carbamazepine, phenytoin, St. John's wort, phenobarbital, primidone); or
    c. Vitamin A at doses higher than the recommended daily allowance (RDA); or
    d. Other oral retinoids (e.g., acitretin, isotretinoin, tretinoin); or
    e. Tetracyclines (e.g., doxycycline, minocycline, tetracycline); and
9. If concurrent use with a moderate CYP3A4 inhibitor (e.g., ciprofloxacin, diltiazem, erythromycin, imatinib, fluconazole, fluvoxamine, verapamil) is required, prescriber must agree to reduce the Sohonos™ dose as recommended in the package labeling; and

10. Prescriber must verify the member or member's caregiver has been counseled on all warnings and precautions related to Sohonos™, including the risks of embryo-fetal toxicity, premature epiphyseal closure, metabolic bone disorders, psychiatric disorders, and night blindness; and
11. The request must specify if it is for a chronic daily dose or a flare-up dose; and
12. Chronic Daily Dose Approvals: Initial approvals will be for the duration of 6 months for the appropriate dose based on member age or weight. For additional approval consideration after 6 months, the prescriber must verify the member is tolerating and responding well to the medication. Subsequent approvals will be for the duration of 1 year; and
13. Flare-Up Dose Approvals: Initial approvals will be for the duration of 12 weeks for the appropriate doses based on member age or weight. After 12 weeks, flare-up dosing may be approved in additional 4-week increments if the prescriber documents the flare-up symptoms have not resolved at the end of the 12-week period; and
14. Member will not be approved for the chronic daily dose and flare-up dosing at the same time.

Recommendation 2: Vote to Prior Authorize Miebo™ and Vevye®

The Drug Utilization Review Board recommends the prior authorization of Miebo™ (Perfluorohexyloctane Ophthalmic Solution) and Vevye® (Cyclosporine Ophthalmic Solution) with the following criteria:

Miebo™ (Perfluorohexyloctane) Approval Criteria:

1. An FDA approved diagnosis of dry eye disease (DED); and
2. Member must be 18 years of age or older; and
3. Prescriber must verify that environmental factors (e.g., humidity, fans) have been addressed; and
4. Member must have trials with at least 3 over-the-counter (OTC) products for 3 days in the last 30 days that failed to relieve signs and symptoms of dry eyes; and
5. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine ophthalmic emulsion) single-use vials, which are available without a prior authorization, and Xiidra® (lifitegrast ophthalmic solution) must be provided; and
6. A quantity limit of 12mL per 30 days will apply.

Vevye® (Cyclosporine 0.1% Solution) Approval Criteria:

1. An FDA approved diagnosis of dry eye disease (DED); and
2. Member must be 18 years of age or older; and

3. Prescriber must verify that environmental factors (e.g., humidity, fans) have been addressed; and
4. Member must have trials with at least 3 over-the-counter (OTC) products for 3 days in the last 30 days that failed to relieve signs and symptoms of dry eyes; and
5. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine ophthalmic emulsion) single-use vials, which are available without prior authorization, and Xiidra® (lifitegrast ophthalmic solution) must be provided; and
6. A quantity limit of 2mL per 50 days will apply.

Recommendation 3: Vote to Prior Authorize Veozah™

The Drug Utilization Review Board recommends the prior Veozah™ (Fezolinetant) with the following criteria:

Veozah™ (Fezolinetant) Approval Criteria:

1. An FDA approved diagnosis of moderate-to-severe vasomotor symptoms (VMS) due to menopause; and
2. Member must not use CYP1A2 inhibitors (e.g., cimetidine, ciprofloxacin, ethinyl estradiol, fluvoxamine, mexiletine) concomitantly with Veozah™; and
3. Member must not have a history of severe renal impairment, end-stage renal disease, or cirrhosis; and
4. Prescriber must verify baseline renal function and member must have an estimated glomerular filtration rate (eGFR) ≥30mL/min/1.73m2; and
5. Prescriber must verify liver function tests (LFTs) (e.g., ALT, AST, bilirubin) will be monitored prior to the initiation of Veozah™, every 3 months for the first 9 months of treatment, and as clinically indicated thereafter; and
6. A patient-specific, clinically significant reason why the member cannot use menopausal hormone therapy must be provided; and
7. A patient-specific, clinically significant reason why the member cannot use other guideline supported non-hormonal therapy for VMS (e.g., gabapentin, paroxetine, venlafaxine) must be provided; and
8. A quantity limit of 30 tablets per 30 days will apply.

Recommendation 4: Vote to Prior Authorize Elrexfio™ and Talvey™

The Drug Utilization Review Board recommends the prior authorization Elrexfio™ (Elranatamab-bcmm) and Talvey™ (Talquetamab-tgvs) with the following criteria:

Pharmacy Agenda Items

Elrexfio™ (Elranatamab-bcmm) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of relapsed or refractory multiple myeloma; and
2. Member has received at least 4 prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody; and
3. Health care facilities must be trained in the management of cytokine release syndrome (CRS), neurologic toxicities, and comply with the risk evaluation and mitigation strategy (REMS) requirements.

Talvey™ (Talquetamab-tgvs) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of relapsed or refractory multiple myeloma; and
2. Member has received at least 4 prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody; and
3. Health care facilities must be trained in the management of cytokine release syndrome (CRS), neurologic toxicities, and comply with the risk evaluation and mitigation strategy (REMS) requirements.

Recommendation 5: Vote to Prior Authorize Rystiggo®, Zilbrysq®, and Vyvgart® Hytrulo

The Drug Utilization Review Board recommends the prior authorization of Rystiggo® (rozanolixizumab-noli), Zilbrysq® (zilucoplan), and Vyvgart® Hytrulo (Efgartigimod alfa/Hyaluronidase-qvfc) with the following criteria:

Rystiggo® (Rozanolixizumab-noli) Approval Criteria [Generalized Myasthenia Gravis (gMG) Diagnosis]:

1. An FDA approved diagnosis of gMG; and
2. Member must be 18 years of age or older; and
3. Member must have a positive serologic test for anti-acetylcholine receptor (AChR) antibodies or anti-muscle-specific tyrosine kinase (MuSK) antibodies; and
4. Member must have a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification class II to IVa; and
5. MG-Activities of Daily Living (MG-ADL) total score ≥3 (with at least 3 points from non-ocular symptoms); and
6. Member must be on a stable dose of either an acetylcholinesterase (AChE) inhibitor or immunosuppressive therapies (ISTs) or a patient specific, clinically significant reason why the member cannot use an AChE inhibitor or an IST must be provided; and
7. Rystiggo® must be prescribed by, or in consultation with, a neurologist,

or a specialist with expertise in the treatment of gMG; and
8. Member must not be receiving Rystiggo® in combination with a complement inhibitor (i.e., Soliris®, Ultomiris®, Zilbrysq®); and
9. Initial approvals will be for the duration of 6 months, at which time an updated MG-ADL score must be provided. Continued authorization requires improvement in the MG-ADL score from baseline. Subsequent approvals will be for the duration of 1 year.

Zilbrysq® (Zilucoplan) Approval Criteria [Generalized Myasthenia Gravis (gMG) Diagnosis]:

1. An FDA approved diagnosis of gMG; and
2. Member must be 18 years of age or older; and
3. Member must have a positive serologic test for anti-acetylcholine receptor (AChR) antibodies; and
4. Member must have a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification class II to IV; and
5. MG-Activities of Daily Living (MG-ADL) total score ≥6; and
6. Member must be on a stable dose of either an acetylcholinesterase (AChE) inhibitor or immunosuppressive therapies (ISTs) or a patient specific, clinically significant reason why the member cannot use an AChE inhibitor or an IST must be provided; and
7. Zilbrysq® must be prescribed by, or in consultation with, a neurologist, or a specialist with expertise in the treatment of gMG; and
8. Prescriber must verify member does not have unresolved Neisseria meningitidis infection; and
9. Prescriber and pharmacy must be enrolled in the Zilbrysq® Risk Evaluation and Mitigation Strategy (REMS) program and maintain enrollment throughout therapy; and
10. Member must not be receiving Zilbrysq® in combination with a neonatal Fc receptor blocker (i.e., Rystiggo®, Vyvgart®, Vyvgart® Hytrulo);
    and
11. For member self-administration or caregiver administration, the prescriber must verify the member or caregiver has been trained by a health care provider on proper administration and storage of Zilbrysq®; and
12. Initial approvals will be for the duration of 6 months, at which time an updated MG-ADL score must be provided. Continued authorization requires improvement in the MG-ADL score from baseline. Subsequent approvals will be for the duration of 1 year.

Vyvgart® Hytrulo (Efgartigimod alfa/Hyaluronidase-qvfc) Approval Criteria [Generalized Myasthenia Gravis (gMG) Diagnosis]:

1. An FDA approved diagnosis of generalized myasthenia gravis (gMG); and
2. Member must be 18 years of age or older; and
3. Member must have a positive serologic test for anti-acetylcholine receptor (AChR) antibodies; and
4. Member must have a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification class II to IV; and
5. MG-Activities of Daily Living (MG-ADL) total score ≥5; and
6. Member must be on a stable dose of either an acetylcholinesterase (AChE) inhibitor or immunosuppressive therapies (ISTs) or a patient specific, clinically significant reason why the member cannot use an AChE inhibitor or an IST must be provided; and
7. Vyvgart® Hytrulo must be prescribed by, or in consultation with, a neurologist, or a specialist with expertise in the treatment of gMG; and
8. Member must not be receiving Vyvgart® or Vyvgart® Hytrulo in combination with a complement inhibitor (i.e., Soliris®, Ultomiris®, Zilbrysq®); and
9. Initial approvals will be for the duration of 6 months, at which time an updated MG-ADL score must be provided. Continued authorization requires improvement in the MG-ADL score from baseline. Subsequent approvals will be for the duration of 1 year.

Recommendation 6: Vote to Prior Authorize Elfabrio®, Opfolda™, and Pombiliti™

The Drug Utilization Review Board recommends the prior authorization of Elfabrio® (Pegunigalsidase Alfa-iwxj), Opfolda™ (Miglustat), and Pombiliti™ (Cipaglucosidase Alfa-atga) with the following criteria:

Elfabrio® (Pegunigalsidase Alfa-iwxj) Approval Criteria:

1. An FDA approved diagnosis of Fabry disease confirmed by 1 of the following:
    a. Molecular genetic testing confirming positive a pathogenic variant in the galactosidase alpha (GLA) gene mutation (results of genetic testing must be submitted); or
    b. Enzyme assay demonstrating a deficiency of alpha-galactosidase A enzyme activity (<5% of normal) (results of assay must be submitted); and
2. Must be prescribed by, or in consultation with, a geneticist or other specialist with expertise in the treatment of Fabry disease; and
3. Requests for Elfabrio® will require a patient-specific, clinically significant reason why the member cannot use Fabrazyme®; and

4. Member will not be approved for concomitant use with Galafold®(migalastat); and
5. Member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
6. Initial approvals will be for the duration of 6 months. After that time, compliance will be required for continued authorization and prescriber must verify the member is responding well to treatment. Subsequent approvals will be for the duration of 1 year if the member is responding well to treatment.

Opfolda™ (Miglustat) and Pombiliti™ (Cipaglucosidase Alfa-atga)
Approval Criteria:

1. An FDA approved diagnosis of late-onset (non-infantile) Pompe disease [acid alpha-glucosidase (GAA) deficiency] confirmed by:
    a. Enzyme assay demonstrating a deficiency of GAA enzyme activity (results of assay must be submitted); or
    b. Molecular genetic testing confirming biallelic pathogenic variants in the GAA gene (results of genetic testing must be submitted); and
2. Member must be 18 years of age or older and weigh ≥40kg; and
3. Prescriber must document presence of symptoms of Pompe disease; and
4. Member must be receiving a different enzyme replacement therapy (ERT) for Pompe disease and not experiencing improvement on the current ERT product; and
5. Female members of reproductive potential must have a negative pregnancy test prior to initiation and must agree to use effective contraception during treatment and for at least 60 days after the final dose; and
6. Pombiliti™ must be administered in a health care setting by a health care provider with appropriate equipment and personnel to manage anaphylaxis. Approvals will not be granted for self-administration; and
    a. Must be shipped via cold chain supply to the health care setting where the member is scheduled to receive treatment; and
7. Must be prescribed by, or in consultation with, a geneticist or other specialist with expertise in the treatment of Pompe disease; and
8. Opfolda™ must be used in combination with Pombiliti™; and
    a. A separate, completed prior authorization request must be received for both medications; and
9. Member will not be approved for concomitant use with other ERT products for Pompe disease; and
10. Member's recent weight must be provided in order to authorize the

appropriate amount of drug required according to package labeling; and

11. For Opfolda™, the following quantity limits will apply:
    a. Weight ≥50kg: 8 capsules per 28 days; or
    b. Weight 40kg to <50kg: 6 capsules per 28 days; and
12. Initial approvals will be for the duration of 6 months, at which time compliance and information regarding efficacy, such as improvement or stabilization in forced vital capacity (FVC) and/or 6-minute walk test (6MWT), will be required for continued approval. Subsequent approvals will be for the duration of 1 year if the member is responding well to treatment.

Recommendation 7: Vote to Prior Authorize Hepzato Kit™ and Zynyz™

The Drug Utilization Review Board recommends the prior authorization Hepzato Kit™ (Melphalan) and Zynyz™ (Retifanlimab-dlwr) with the following criteria:

Hepzato Kit™ (Melphalan) Approval Criteria [Uveal Melanoma Diagnosis]:

1. Diagnosis of metastatic uveal melanoma; and
2. Presence of hepatic metastases affecting <50% of the liver; and
3. No other extrahepatic metastases; or
4. Presence of extrahepatic metastases limited to the bone, lymph nodes, subcutaneous tissue, and/or lung that is amenable to resection or radiation.

Zynyz™ (Retifanlimab-dlwr) Approval Criteria [Merkel Cell Carcinoma (MCC) Diagnosis]:

1. Diagnosis of metastatic or recurrent locally advanced MCC; and
2. Member must be 18 years of age or older; and
3. A maximum treatment duration of 24 months will apply.

Recommendation 8: Vote to Prior Authorize Iwilfin™, Kepivance®, Loqtorzi™, and Omisirge®

The Drug Utilization Review Board recommends the prior authorization Iwilfin™ (Eflornithine), Kepivance® (Palifermin), Loqtorzi™ (Toripalimab-tpzi), and Omisirge® (Omidubicel-onlv) with the following criteria:

Iwilfin™ (Eflornithine) Approval Criteria [Neuroblastoma Diagnosis]:

1. Diagnosis of high-risk neuroblastoma (HRNB); and
2. Member has had at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy; and
3. Used as a single agent to reduce the risk of relapse for a maximum of 2 years; and
4. Member's recent body surface area (BSA) must be provided.

Kepivance® (Palifermin) Approval Criteria [Oral Mucositis Associated with Autologous Stem Cell Transplant Conditioning Diagnosis]:

1. Diagnosis of hematologic malignancy; and
2. Undergoing autologous stem cell transplantation; and
3. Using a preparative regimen predicted to result in ≥Grade 3 mucositis in >50% of patients; and
4. The preparative regimen and a reference for the preparative regimen must be provided; and
    a. Single dose melphalan 200mg/m^2 is not included as an appropriate preparative regimen due to lack of efficacy of palifermin with this regimen.

Loqtorzi™ (Toripalimab-tpzi) Approval Criteria [Nasopharyngeal Carcinoma (NPC) Diagnosis]:

1. Diagnosis of metastatic or recurrent, locally advanced NPC; and
    a. Used in the first-line setting; and
    b. Used in combination with cisplatin and gemcitabine; and
    c. Dose as follows:
        i. 240mg every 3 weeks; and
        ii. Maximum duration of 2 years; or
2. Diagnosis of previously treated recurrent unresectable or metastatic NPC; and
    a. Disease has progressed on or following a platinum-containing chemotherapy; and
    b. Used as a single agent; and
    c. Dose as follows:
        i. 3mg/kg every 2 weeks.

Omisirge® (Omidubicel-onlv) Approval Criteria:

1. Member is 12 years of age or older; and
2. Diagnosis of hematological malignancy; and
3. Allogeneic stem cell transplant using umbilical cord blood donor source is planned; and
    a. Documentation of the donor source must be provided; and

4. Myeloablative conditioning regimen will be used; and
    a. Documentation of the member's conditioning regimen must be provided; and
5. Will be used to reduce time to neutrophil recovery and incidence of infection.

Recommendation 9: Vote to Prior Authorize Ogsiveo™

The Drug Utilization Review Board recommends the prior Ogsiveo™ (Nirogacestat) with the following criteria:

Ogsiveo™ (Nirogacestat) Approval Criteria [Desmoid Tumor Diagnosis]:

1. Diagnosis of desmoid tumor; and
2. Tumor is progressing, requiring systemic treatment; and
3. As a single agent.

Recommendation 10: Vote to Prior Authorize Renagel® and Xphozah®

The Drug Utilization Review Board recommends the prior Renagel® (Sevelamer Hydrochloride) and Xphozah® (Tenapanor) with the following criteria:

Renagel® (Sevelamer Hydrochloride) Approval Criteria:

1. An FDA approved indication for the control of serum phosphorus in members with chronic kidney disease (CKD) on dialysis; and
2. A patient-specific, clinically significant reason why the member cannot use Renvela® (sevelamer carbonate) 800mg tablets or other phosphate binders available without prior authorization must be provided.

Xphozah® (Tenapanor) Approval Criteria:

1. An FDA approved indication to reduce serum phosphorus in adults with chronic kidney disease (CKD) on dialysis; and
2. Member must be 18 years of age or older; and
3. Documented trials of inadequate response to at least 2 of the phosphate binders available without prior authorization or a patientspecific, clinically significant reason why the member cannot use all phosphate binders available without prior authorization must be provided; and
4. Documented trial of inadequate response to at least 1 iron-based phosphate binder [e.g., Auryxia® (ferric citrate), Velphoro® (sucroferric oxyhydroxide)] or a patient-specific clinically significant reason why the

member cannot use an iron-based phosphate binder must be provided.

Recommendation 11: Vote to Prior Authorize iDose® TR

The Drug Utilization Review Board recommends the prior iDose® TR (Travoprost Intracameral Implant) with the following criteria:

iDose® TR (Travoprost Intracameral Implant) Approval Criteria:

1. An FDA approved indication to reduce intraocular pressure (IOP) in members with open-angle glaucoma (OAG) or ocular hypertension (OHT); and
2. Member must be 18 years of age or older; and
3. iDose® TR must be prescribed by, or in consultation with, an ophthalmologist; and
4. A patient-specific, clinically significant reason why the member requires iDose® TR and cannot utilize ophthalmic preparations, such as solution or suspension, to treat OAG or OHT must be provided; and
5. A patient-specific, clinically significant reason why the member cannot use Durysta® (bimatoprost intracameral implant) must be provided; and
6. The affected eye has not received prior treatment with iDose® TR; and
7. Member has no contraindications to iDose® TR; and
8. A quantity limit of (1) iDose® TR 75mcg implant per eye per lifetime will apply.

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OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

PER DIEM RATE FOR FREESTANDING REHABILITATION HOSPITALS OPERATED BY UNITS OF GOVERNMENT

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate and Method Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   No Impact

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority is proposing to increase the per diem rate for freestanding rehabilitation hospitals operated by units of government to $2,325.00 effective 3/1/2024.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate structure for freestanding rehabilitation hospitals operated by units of government is a per diem rate of $1,065.67 and a cost settlement is completed at the end of the year. According to the Oklahoma State Plan, the settlement can not exceed 100% of their allowable costs under Medicare payment principles.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed rate structure for freestanding rehabilitation hospitals operated by units of government would still be a per diem rate and receive a cost settlement at the end of the year that would not exceed 100% of their allowable costs under Medicare payment principles. Since the per diem has not been updated in several years, the cost settlement is now larger than the per diem payment. The new per diem rate would be $2,325.00 and would be updated annually to not exceed 100% of their allowable costs under Medicare payment principles. This would reduce the cost settlement and spread the amount of the current cost settlement out over the entire year.

6. **BUDGET ESTIMATE.**
   The impact for SFY 2024 and SFY2025 will be budget neutral. The state share is paid by freestanding rehabilitation hospitals operated by units of government, for example, J D McCarty Center.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   This will have no impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the proposed per diem rate increase to freestanding rehabilitation hospitals operated by units of government to $2,325.00 and be updated annually to not exceed 100% of their allowable costs under Medicare payment principles.

9. **EFFECTIVE DATE OF CHANGE.**
   March 1, 2024

SUBMITTED TO THE C.E.O. AND BOARD ON March 20, 2024
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Medicaid Management Information System
Purpose and Scope	Oklahoma Health Care Authority is seeking to extend the current contract for FY25-FY27 The Board previously approved a contract extension in 2017 of the approved contract 2010 for MMIS Fiscal Agent Services. Expenditure of authority is requested for an amendment to extend the contract through a sole source with Gainwell through 2027. OHCA will seek to gain approval from OMES and the Center of Medicare and Medicaid Services (CMS) to extend the Gainwell Technologies contract based on the following justifications: 1. Federal regulations require alignment with Medicaid Information Technology Architecture (MITA) for Medicaid systems that are funded with enhanced federal matching funds. Medicaid agencies are required to modernize their systems to enhance interoperability through modular design to promote sharing and reuse with other states. While OHCA develops their strategy to modernize the system and prepares solicitations for modernization, OHCA needs to maintain the current core system provided by Gainwell Technologies to continue current Medicaid operations to receive enhanced funding. MMIS service scope includes: • System Integrator, responsible to coordinate system core operations with modular components provided by separate contractors. • Federal mandates for new claim formats and new diagnosis codes. • Edit and audit functions for MMIS claims processing. • Online enrollment and eligibility. • Insure Oklahoma • Rules engines to provide efficiency to process claims and enrollment applications. • Program Integrity (PI) system with technologies for fraud detection and case tracking.
Mandate	• 1903(a)(3) of the Social Security Act defined in Federal Code 42 CFR 433.111 • Federal Code 42 CFR 433.112(b)(11)
Procurement Method	Original acquisition was made by Competitive Bid. Extension is authorized by Sole Source.

External Approvals	CMS
Contract Term	July 1, 2024, through June 30, 2025, with two (2) extensions ending June 30, 2027

BUDGET

Amount requested for approval	Increase Not to Exceed $180,000,000.00 for FY25- FY27
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Administration 75% Operations 50%

RECOMMENDATION
Board approval to expend funds as explained above.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 days for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $1,000,000.00 or25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

SUBMITTED TO THE C.E.O. AND BOARD ON MARCH 20, 2024
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	**Asset Verification System Services**
Purpose and Scope	In compliance with the asset verification mandates stipulated by 42 USC 1396w, the Oklahoma Health Care Authority (OHCA) initiated a contract on January 16, 2016, to implement Asset Verification Services (AVS). The AVS Program verify the assets of aged, blind, and disabled individuals applying or reapplying for SoonerCare; • Report the assets of the above referenced population to DHS; • Establish a network of FIs within the State of Oklahoma and the other 49 states, US possessions and territories depending on the banking laws in those various locations; and • Maintain a collegial relationship with the various financial institutions (FI).
Mandate	42 USC 1396w
Procurement Method	Request for Proposal
External Approvals	OMES
New Contract Term	Base year with five (5) renewal periods

BUDGET

Amount requested for Approval	$3,850,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to reprocure these services for

base year cost of $850,000.00 and five (5) renewal options funded at $600,000.00/year for a total not-to-exceed of $3,850,000.00.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

March 20, 2024 Board
Proposed Rule Amendment Summaries

The proposed **EMERGENCY** rules were presented at the **January 2, 2024** Tribal Consultation and were subject to at least a 15-day public comment period and were considered by the Medical Advisory Committee on March 7, 2024.

The Governor will have until May 4, 2024, to approve or disapprove each rule upon the Agency's submission for gubernatorial review.

Agency is requesting the effective date to be immediately upon receiving gubernatorial approval.

APA WF # 24-03 Collaborative Care Model Reimbursement – The proposed emergency revisions amend rules to comply with state statute at Title 36 Oklahoma Statute § 6060.11a. Senate Bill 444 of the 2023 legislative session directed the agency to implement a "Collaborate Care Model" by requiring reimbursement for behavioral health and substance use disorder services delivered in a primary care setting. The proposed revisions will add “behavioral health integration” as a covered physician’s service. The agency is developing medical guidelines that address documentation and limits to ensure proper utilization and billing.

Budget Impact: The estimated budget impact for SFY 2024 will be an increase in the total amount of $127,262; with $41,322 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $1,527,145; with $501,056 in state share.

APA WF # 24-04 Hospital Provision of Opioid Antagonist – The proposed emergency revisions amend rules to comply with state statute at Title 43A Oklahoma Statute § Section 2-401.2. Senate Bill 712 of the 2023 legislative session directed the agency to reimburse for opioid antagonists separately when provided to members with symptoms of an opioid overdose, opioid disorder, or any other adverse opioid event related to opioid use in a hospital emergency department.

Budget Impact: The estimated budget impact for SFY 2024 will be an increase in the total amount of $142,203; with $46,173 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $284,406; with $93,314 in state share.

APA WF # 24-05 Private Duty Nursing (PDN) Coverage Limitations Change – The proposed emergency policy revisions are intended to provide families and PDN agencies with the flexibility to staff cases according to the family's need and the member's level of care. Revisions will clarify the criteria for virtual visits when a member is assessed for PDN services. Other policy revisions will change the designated care hours from "per day" to "per week". Language will be amended to reflect maximum hours authorized from 16 hours per day to 112 hours per week. Revisions will also add that a member's medical necessity can be determined by an OHCA physician's appointed designee.

Budget Impact: Budget neutral.

The proposed **EMERGENCY** rules were presented at the **March 5, 2024** Tribal Consultation and were subject to at least a 15-day public comment period and were considered by the Medical Advisory Committee on March 7, 2024.

APA WF # 24-12 Medication Limits – These emergency revisions are necessary to protect

public health, safety, and/or welfare by removing the list of medications exempt from the prescription limits policy, as the list will be hosted on the OHCA website instead. The rule revision and accompanying State Plan amendment are intended to streamline the process of adding new exemptions. New exemptions will be approved by a committee including representatives from Pharmacy and Finance before being posted online.

Budget Impact: Budget neutral.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults**. Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes, but is not limited to, the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One (1) inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies.

(G) Physician services on an outpatient basis include:

(i) A maximum of four (4) visits per member per month, including primary care or specialty, with the exception of SoonerCare Choice members.

(ii) Additional visits are allowed per month for treatment related to emergency medical conditions and family planning services.

(H) Direct physician services in a nursing facility.

(i) A maximum of two (2) nursing facility visits per month are allowed; and if the visit (s) is for psychiatric services, it must be provided by a psychiatrist or a physician with appropriate behavioral health training.

(ii) To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the explanation of Medicare benefits (EOMB) showing denial and mark "carrier denied coverage."

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms as per current guidelines.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, Oklahoma Department of Human Services (OKDHS) form 08MA016E, Authorization for Examination and Billing, must accompany the claim.

(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members twenty-one (21) years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling.
(Q) Laboratory testing.
(R) Payment for ultrasounds for pregnant women as specified in Oklahoma Administrative Code (OAC) 317:30-5-22.
(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.
(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met:

(i) Attending physician performs chart review and signs off on the billed encounter;
(ii) Attending physician is present in the clinic/or hospital setting and available for consultation; and
(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(U) Payment for services rendered by medical residents in an outpatient academic setting when the following conditions are met:

(i) The resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and
(ii) Has the appropriate contract on file with the OHCA to render services within the scope of their licensure.

(V) The payment to a physician for medically directing the services of a certified registered nurse anesthetist (CRNA) or for the direct supervision of the services of an anesthesiologist assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.
(W) Screening and follow up pap smears as per current guidelines.
(X) Medically necessary organ and tissue transplantation services for children and adults are covered services based upon the conditions listed in (i)-(v) of this subparagraph:

(i) All transplantation services, except kidney and cornea, must be prior authorized;
(ii) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;
(iii) All organ transplants must be performed at a Medicare-approved transplantation center;

(iv) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

(v) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(Y) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the ninety (90) day global reimbursement period must be submitted to the OHCA for review.

(Z) Total parenteral nutritional (TPN) therapy for identified diagnoses and when prior authorized.

(AA) Ventilator equipment.

(BB) Home dialysis equipment and supplies.

(CC) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy." Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(DD) Smoking and tobacco use cessation counseling for treatment of members using tobacco.

(i) Smoking and tobacco use cessation counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight (8) sessions are covered per year per individual.

(iii) Smoking and tobacco use cessation counseling is a covered service when performed by physicians, physician assistants (PA), advanced registered nurse practitioners (ARNP), certified nurse midwives (CNM), dentists, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nursing staff, and maternal/child health licensed clinical social worker trained as a certified tobacco treatment specialist (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, primary care provider (PCP) care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note that addresses the 5A's and office note signature along with the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit and not separately billable.

(EE) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(FF) Genetic testing and other molecular pathology services are covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition, is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified) or has been diagnosed with a condition where identification of specific genetic changes will impact treatment or management; and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) A medical geneticist, physician, or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(GG) Behavioral Health Integration Services. For full guidelines, please refer to www.okhca.org/mau.

(2) General coverage exclusions include, but is not limited to, the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(J) Payment for more than four (4) outpatient visits per member (home or office) per month, except visits in connection with family planning, services related to emergency medical conditions, or primary care services provided to SoonerCare Choice members.

(K) Payment for more than two (2) nursing facility visits per month.

(L) More than one (1) inpatient visit per day per physician.

(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).

(Q) Speech and hearing services.

(R) Mileage.

(S) A routine hospital visit on the date of discharge unless the member expired.

(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(U) Inpatient chemical dependency treatment.

(V) Fertility treatment.

(W) Payment for removal of benign skin lesions.

(b) **Children**. Payment is made to physicians for medical and surgical services for members under the age of twenty-one (21) within the scope of the SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services**. All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by an agency designated by the OHCA. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All inpatient psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25, 317:30-5-95.27 and 317:30-5-95.29.

(B) For out of state placements, refer to OAC 317:30-3-89 through 317:30-3-92.

(2) **General Acute inpatient service limitations**. All general Acute inpatient hospital services for members under the age of twenty-one (21) are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services**. The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are

final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under twenty-one (21) years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment (EPSDT) program.** Payment is made to eligible providers for EPDST of members under age twenty-one (21). These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.12 for specific guidelines.

(6) **Reporting suspected abuse and/or neglect**. Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, Section 1-2-101 of Title 10A of the Oklahoma Statutes and 43A O.S. _ 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local OKDHS county office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. _ 58.

(7) **General exclusions.** The following are excluded from coverage for members under the age of twenty-one (21):

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by CPT and CMS.

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(G) Non-therapeutic hysterectomies.

(H) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(I) More than one (1) inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).

(K) Physician services which are administrative in nature and not a direct service to the

member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Mileage.

(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The EOMB reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within ninety (90) days of the date of Medicare payment and within one (1) year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over." Providers must file a claim for coinsurance and/or deductible to SoonerCare within ninety (90) days of the Medicare payment and within one (1) year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the EOMB showing the reason for the denial.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.7. Emergency department (ED) care/services

Emergency department care must:

(1) Be provided in a hospital with a designated emergency department; and

(2) Provide direct patient care, including patient assessment, monitoring, and treatment by hospital medical personnel such as physicians, nurses, or lab and x-ray technicians.

(A) Medical records must document the emergency diagnosis and the extent of direct patient care.

(B) Emergency department care does not include unattended waiting time.

(C) Emergency services are covered for a medical emergency. This means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(i) Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or continuation of severe pain;

(ii) serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or death.

(D) Labor and delivery is a medical emergency, if it meets this definition.

(3) Prescheduled services are not considered an emergency.

(4) Services provided as follow-up to initial emergency care are not considered emergency services.

(5) Include provision of emergency opioid antagonist upon discharge as per state law.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) Laboratory services;

(B) Prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants,

implantable pumps;

(C) Technical component on radiology services;

(D) Transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) Pre-admission diagnostic testing performed within seventy-two (72) hours of admission; and

(F) Organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.

(5) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed one-hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

(10) All inpatient services are reimbursed per the methodology described in this Section and/or as approved under the Oklahoma Medicaid State Plan.

(11) For high-investment drugs, refer to OAC 317:30-5-47.6.

(12) Separate reimbursement may be obtained for provision of two (2) doses of emergency opioid antagonist upon discharge as per state law.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 62. PRIVATE DUTY NURSING

317:30-5-558. Private duty nursing (PDN) coverage limitations

The following provisions apply to all PDN services and provide coverage limitations:

(1) All services must be prior authorized to receive payment from the Oklahoma Health Care Authority (OHCA). Prior authorization means authorization in advance of services provided in accordance with Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-560.1;

(2) A treatment plan must be completed by an eligible PDN provider before requesting prior authorization and must be updated at least annually and signed by the physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN)];

(3) An assessment by an OHCA care management nurse is required prior to the authorization for services. The assessment will be conducted by the OHCA through one (1) of the following:

(A) ~~Telephone;~~**Telephone.** Audio-only telephonic communication;

(B) ~~Virtually; or~~**Virtually.** Virtual visits are the standard method of assessment. This is a means to use virtual technology to collect medical and other forms of health data for the purposes of assessment and recommendation; or

(C) ~~Face-to-face;~~**Face-to-face.** In person face-to-face assessments are completed when determined by OHCA to be the most appropriate assessment method. A face-to-face assessment is not completed at the parent or caregiver's request.

(4) Care in excess of the designated hours per ~~day~~week granted in the prior authorization is not SoonerCare compensable. Prior-authorized but unused service hours cannot be ~~"banked," "saved," or otherwise "accumulated"~~accumulated for use at a future date or time. If such hours or services are provided, they are not SoonerCare compensable.

(5) Any medically necessary PDN care provided outside of the home must be counted in and cannot exceed the number of hours requested on the treatment plan and approved by OHCA.

(6) PDN services do not include office time or administrative time in providing the service. The time billed is for direct nursing services only.

(7) Staff must be engaged in purposeful activity that directly benefits the member receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will OHCA compensate an organization for nursing staff time when sleeping.

(8) OHCA will not approve PDN services if all health and safety issues cannot be met in the setting in which services are provided.

(9) A provider must not misrepresent or omit facts in a treatment plan.

(10) It is outside the scope of coverage to deliver care in a manner outside of the treatment plan or to deliver units over the authorized units of care.

(11) PDN is not authorized in excess of 112 hours per week, not exceeding sixteen (16) hours per day. There may be approval for additional hours for a period not to exceed thirty (30) days, if:

(A) The member has an acute episode that would otherwise require hospitalization or immediately following a hospital stay; or

(B) The primary caregiver is temporarily and involuntarily unable to provide care.

(C) The OHCA has discretion and the final authority to approve or deny any additional PDN hours and will take into consideration that the additional hours are not to be a substitute for institutionalized care.

(12) Family and/or caregivers and/or guardians (hereinafter, "caregivers") are required to provide some of the nursing care to the member without compensation. PDN services shall not be provided solely to allow the member's caregiver to work or go to school, nor solely to allow respite for the caregiver.

(13) PDN services will not be approved for overnight trips away from the member's primary residence that are unrelated to medically necessary treatment or medical care.

(A) For a member to receive Medicaid-reimbursable PDN services on an overnight trip that is related to medically necessary treatment or medical care, all provisions of this Part must be met. If said trip occurs out of state, OAC 317:30-3-89 through 317:30-3-92 must also be met.

(B) In instances in which the member's family is temporarily absent due to vacations, any additional PDN hours must be paid for by the family, or provided by other trained family members without SoonerCare reimbursement.

(14) PDN services will not be approved when services are reimbursed or reimbursable by other insurance, other governmental programs, or Medicaid program services that the member receives or is eligible to receive. For example, if a member receives Medicaid-reimbursable PDN services pursuant to an Individualized Education Program (IEP) in a public school, then those PDN school hours will be counted in the member's daily allotment of PDN services.

317:30-5-559. How Private Duty Nursing (PDN) services are authorized

PDN services may be initiated after completion of the following steps:

(1) A treatment plan for the patient has been created by an eligible PDN provider per Oklahoma Administrative Code (OAC) 317:30-5-560;

(2) A prior authorization request is submitted with the appropriate Oklahoma Health Care Authority (OHCA) required data elements and the treatment plan;

(3) An assessment (telephonic, virtual, or face-to-face) has been conducted by an OHCA care management nurse, per OAC 317:30-5-558 (3); and

(4) An OHCA physician, or his or her designee, has determined the medical necessity of the service, including but not limited to, scoring the member's needs on the OHCA PDN assessment.

317:30-5-560. Treatment plan

(a) An eligible organization must create a treatment plan for the member as part of the authorization process for private duty nursing (PDN) services. The initial treatment plan must be signed by the member's attending physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN).

(b) The treatment plan must include all of the following:

(1) Diagnosis;

(2) Prognosis;

(3) Anticipated length of treatment;

(4) Number of PDN requested hours per ~~day;~~week;

(5) Assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks,

respiratory);
(6) Medication method of administration and frequency;
(7) Age-appropriate feeding requirements (diet, method and frequency);
(8) Respiratory needs;
(9) Mobility requirements including need for turning and positioning, and the potential for skin breakdown;
(10) Developmental deficits;
(11) Casting, orthotics, therapies;
(12) Age-appropriate elimination needs;
(13) Seizure activity and precautions;
(14) Age-appropriate sleep patterns;
(15) Disorientation and/or combative issues;
(16) Age-appropriate wound care and/or personal care;
(17) Communication issues;
(18) Social support needs;
(19) Name, skill level, and availability of all caregivers; and
(20) Other pertinent nursing needs such as dialysis, isolation.

317:30-5-560.1. Prior authorization requirements

(a) Authorizations are provided for a maximum period of six (6) months.
(b) Authorizations require:
(1) A treatment plan for the member;
(2) An assessment (telephonic, virtual, or face-to-face) has been conducted by an Oklahoma Health Care Authority (OHCA) care management nurse, per Oklahoma Administrative Code (OAC) 317:30-5-558 (2); and
(3) An OHCA physician, or his or her designee, to determine medical necessity including use of the OHCA Private Duty Nursing (PDN) assessment.
(c) The number of hours authorized may differ from the hours requested on the treatment plan based on the review by an OHCA physician.
(d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.
(e) Changes in the treatment plan may necessitate another assessment (telephonic, virtual, or face-to-face) by an OHCA care management nurse.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six (6) covered prescriptions per month with a limit of two (2) brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six (6) covered prescriptions for the month.

(2) Subject to the limitations set forth in Oklahoma Administrative Code (OAC) 317:30-5-72.1, 317:30-5-77.2, and 317:30-5-77.3, exceptions to the six (6) medically necessary prescriptions per month limit are:

(A) Unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of nursing facilities (NF) or intermediate care facilities for individuals with an intellectual disability (ICF/IID); and

(B) Seven (7) additional medically necessary prescriptions which are generic products per month to the six (6) covered under the State Plan [including three (3) brand name prescriptions] are allowed for adults receiving services under the 1915(c) Home and Community-Based Services (HCBS) waivers. Medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions will be covered with prior authorization.

(3) For purposes of this Section, "exempt from the prescription limit" means claims filed for ~~any of these~~certain prescriptions will not count toward the prescriptions allowed per month. A complete list of the selected drugs exempt from monthly limits can be viewed on the agency's website at www.okhca.org/rx.~~Drugs exempt from the prescription limit include:~~

~~(A) Antineoplastics;~~

~~(B) Anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV);~~

~~(C) Frequently monitored prescription drugs. A complete list of the selected drugs considered as frequently monitored can be viewed on the agency's website at www.okhca.org.~~

~~(D) Medication-assisted treatment (MAT) drugs for opioid use disorder;~~

~~(E) Contraceptives;~~

~~(F) Hemophilia drugs;~~

~~(G) Compensable smoking and tobacco cessation products;~~

~~(H) Naloxone for use in opioid overdose;~~

~~(I) Certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.);~~

~~(J) Drugs used for the treatment of tuberculosis; and~~

~~(K) Prenatal vitamins.~~

(4) When a brand drug is preferred over its generic equivalent due to lower net cost, that drug shall not count toward the brand limit; however, it will count toward the monthly prescription limit.

(b) **Coverage for children**. Prescription drugs for SoonerCare eligible individuals under twenty-one (21) years of age are not limited in number per month, but may be subject to prior authorization, quantity limits or other restrictions.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

OPERATIONAL METRICS

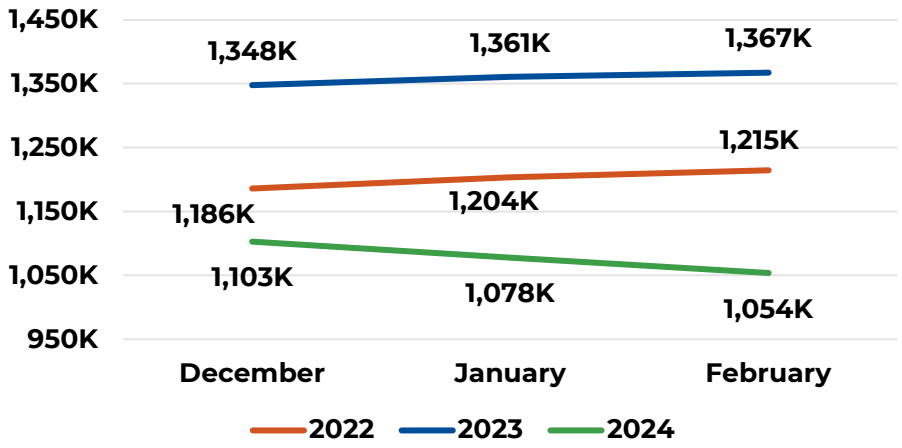
March 2024 Board Meeting

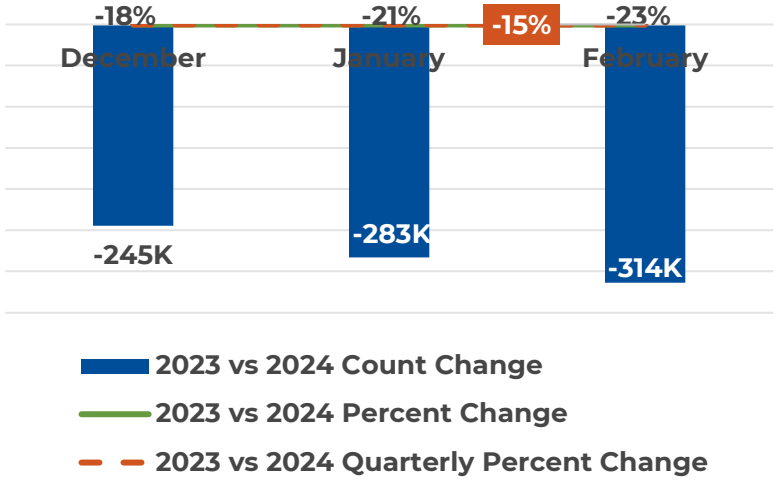
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

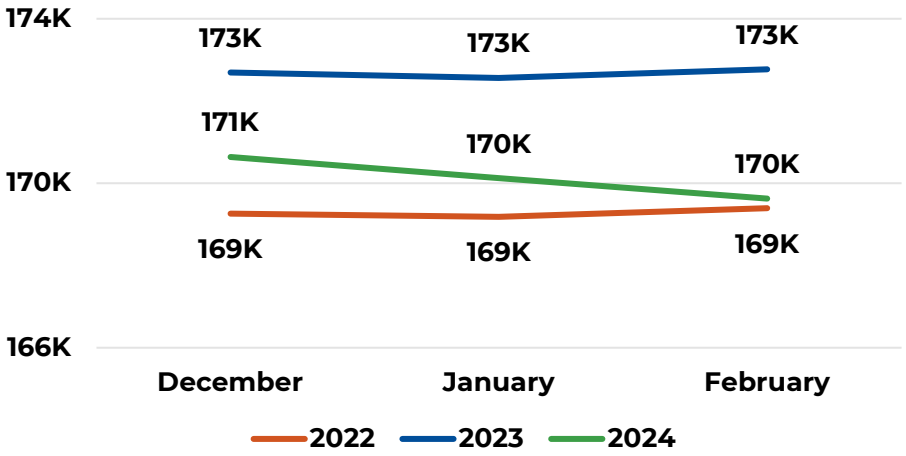
Enrollment & Utilization

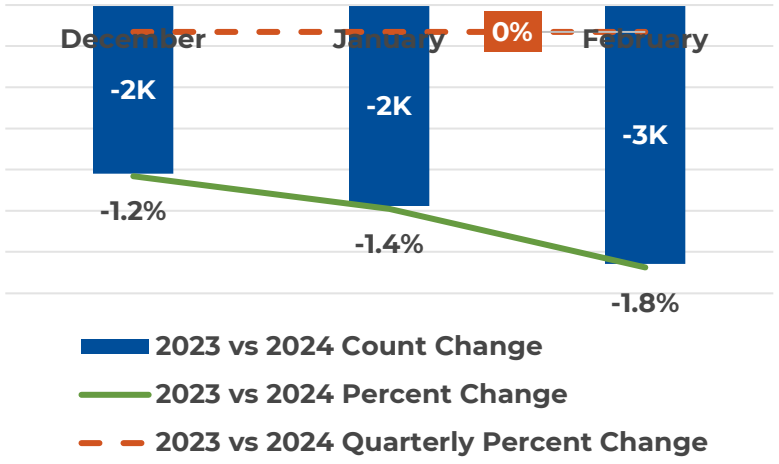
Total Enrolled Members





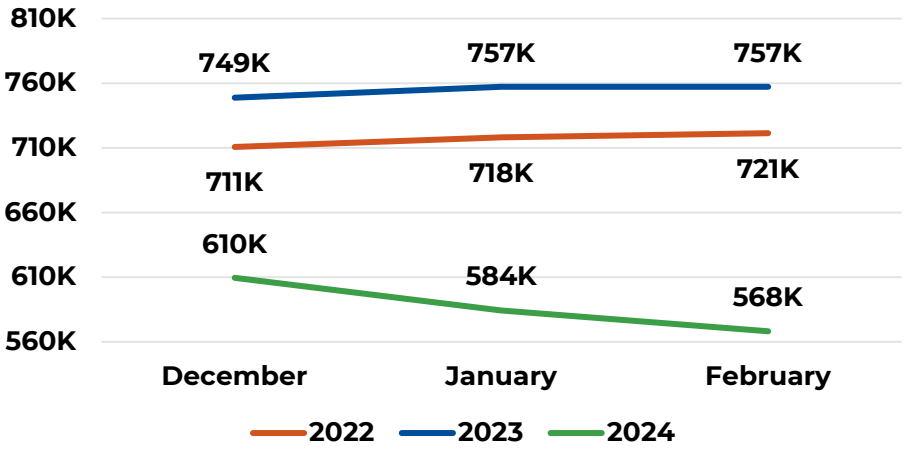
Aged/Blind/Disabled Enrolled

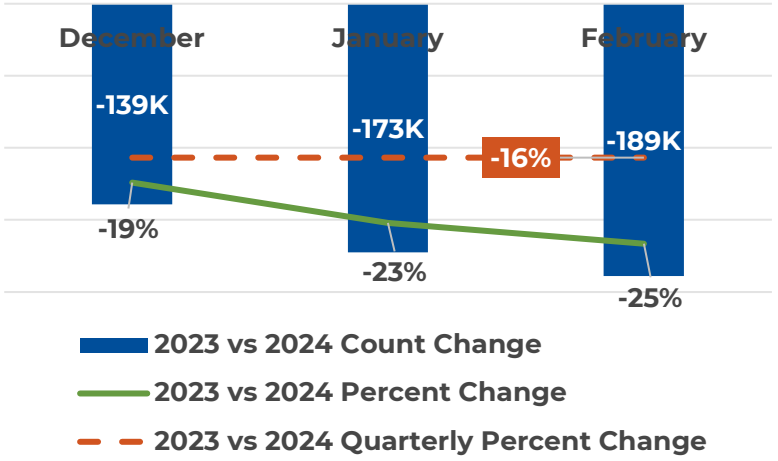




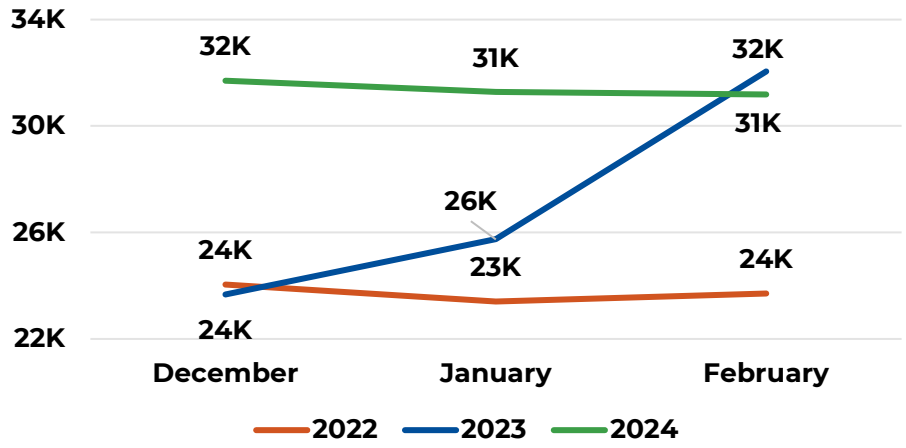
Enrollment & Utilization (Cont.)

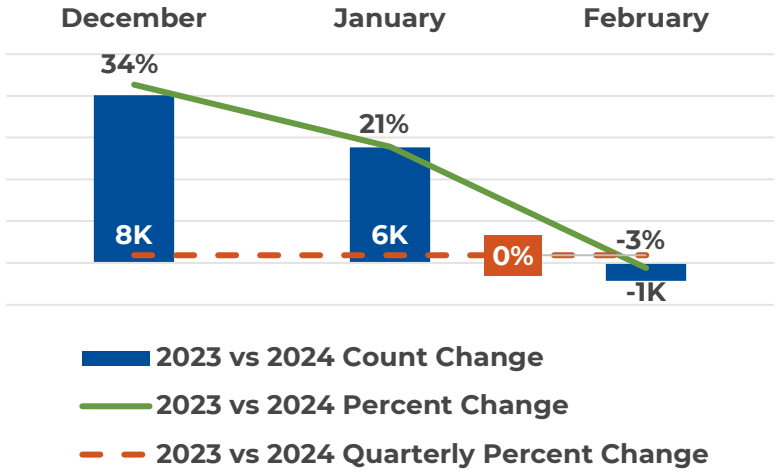
Children & Parent/Caretaker Enrolled





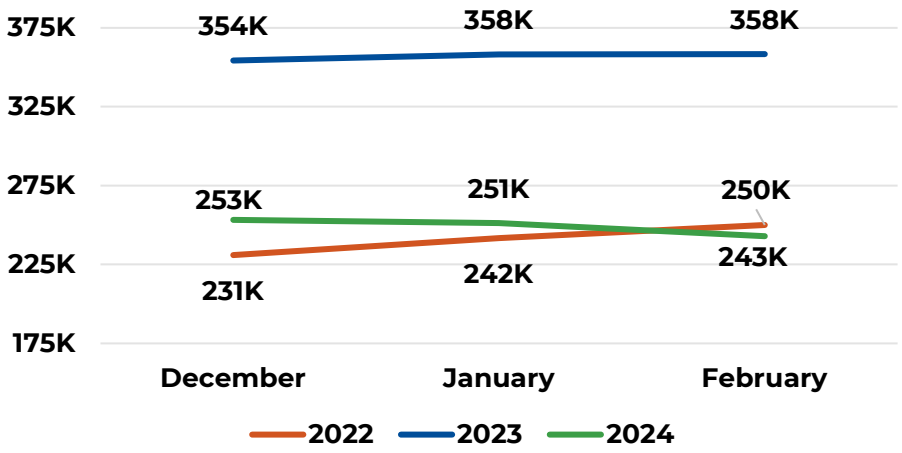
Pregnant (Full Scope) Enrolled

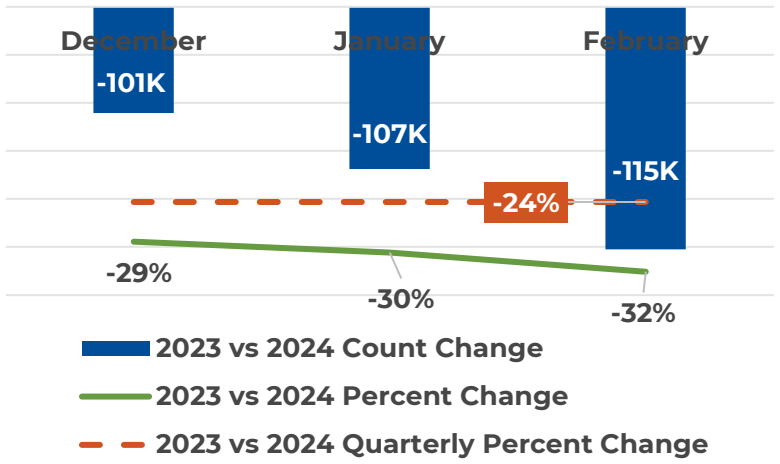




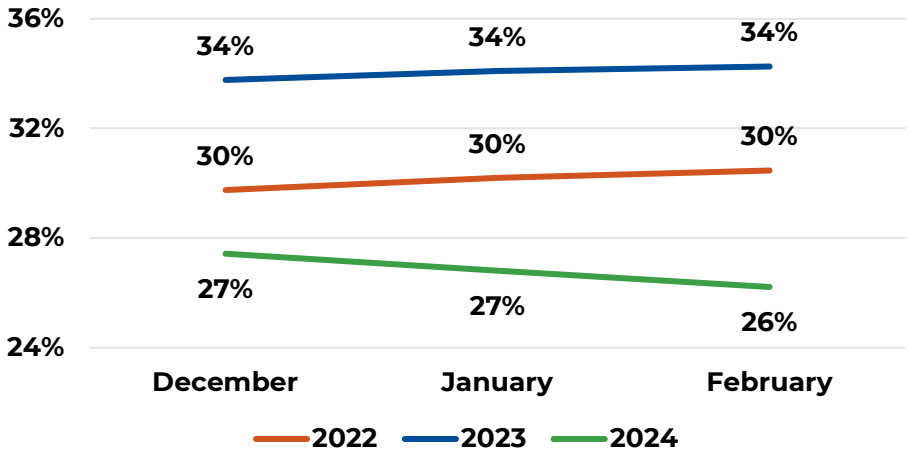
Enrollment & Utilization (Cont.)

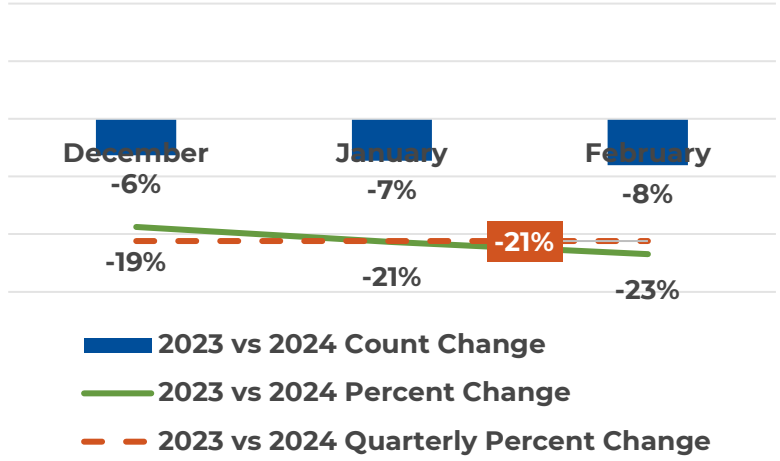
Expansion Enrolled (Effective July 2021)





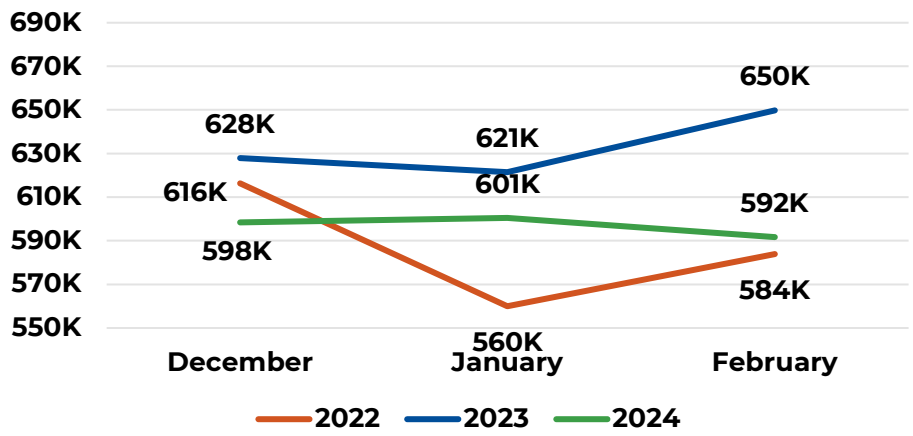
Percent of OK Population Enrolled

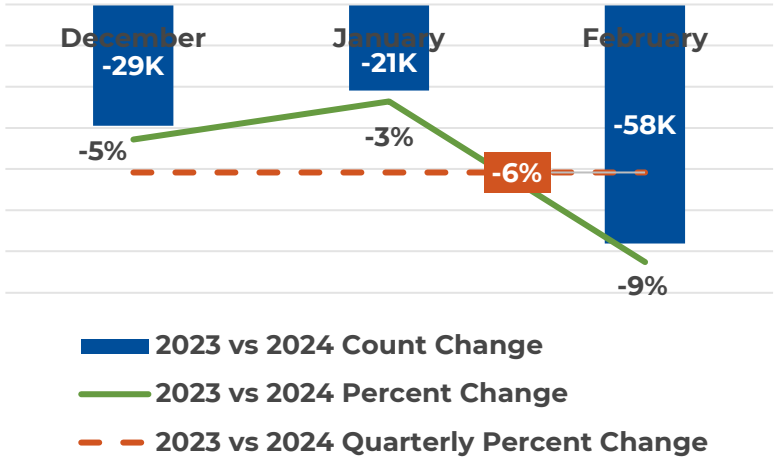




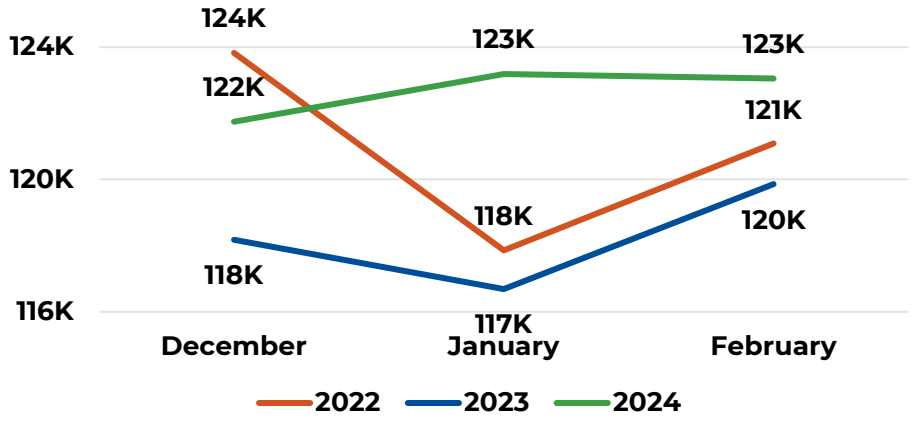
Enrollment & Utilization (Cont.)

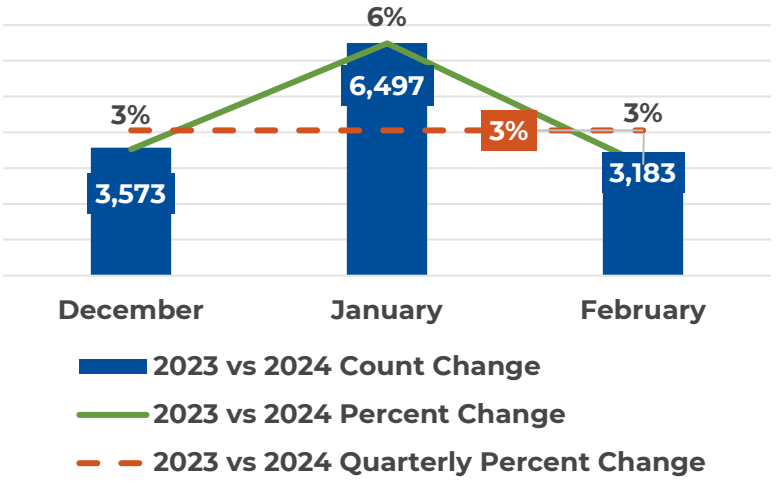
Total Members Utilization





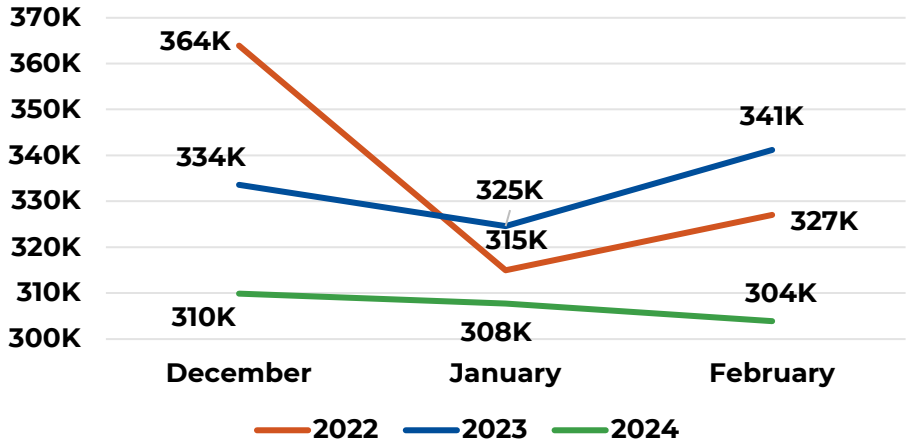
Aged/Blind/Disabled Utilization

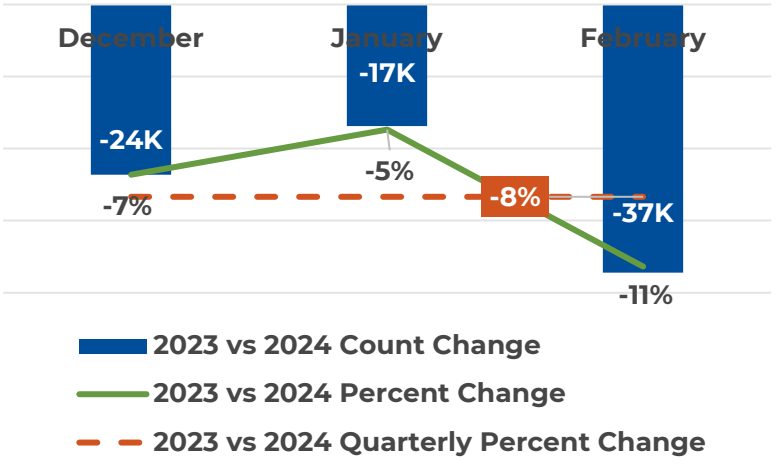




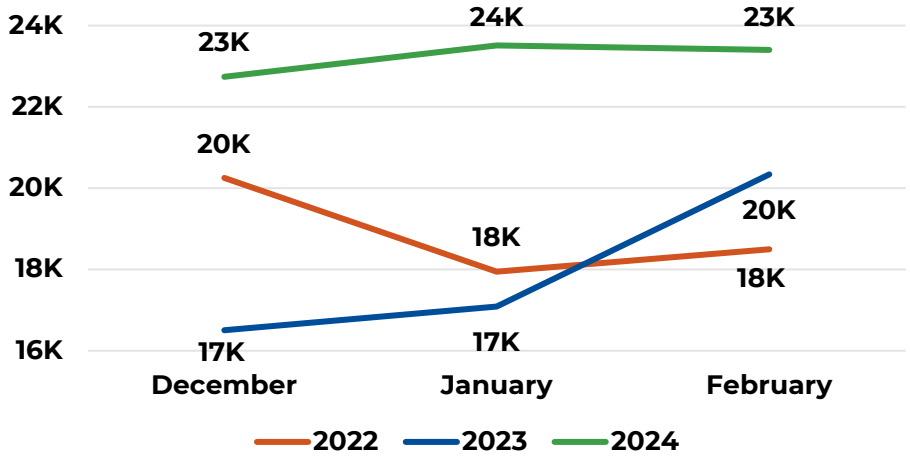
Enrollment & Utilization (Cont.)

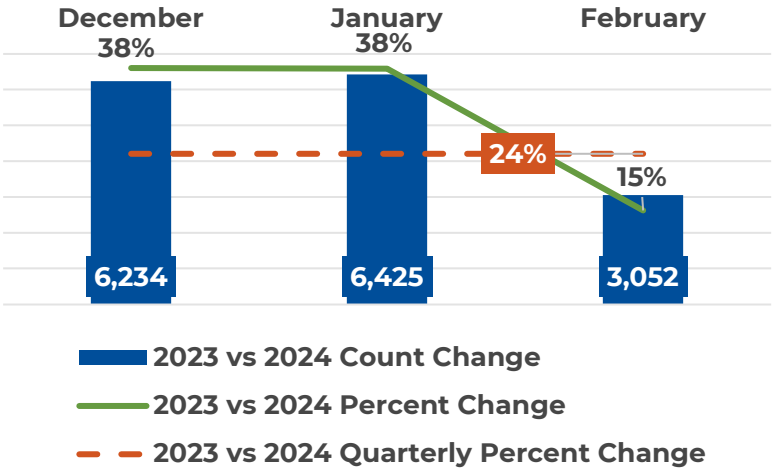
Children & Parent/Caretaker Utilization





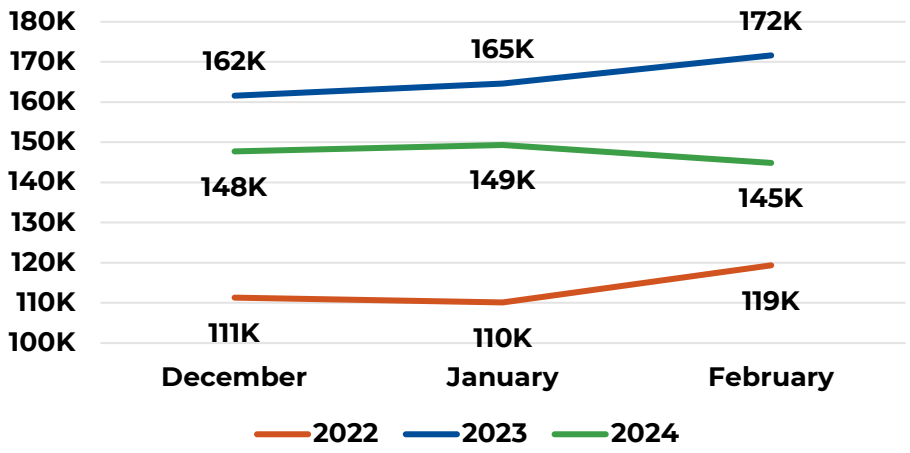
Pregnant (Full Scope) Utilization

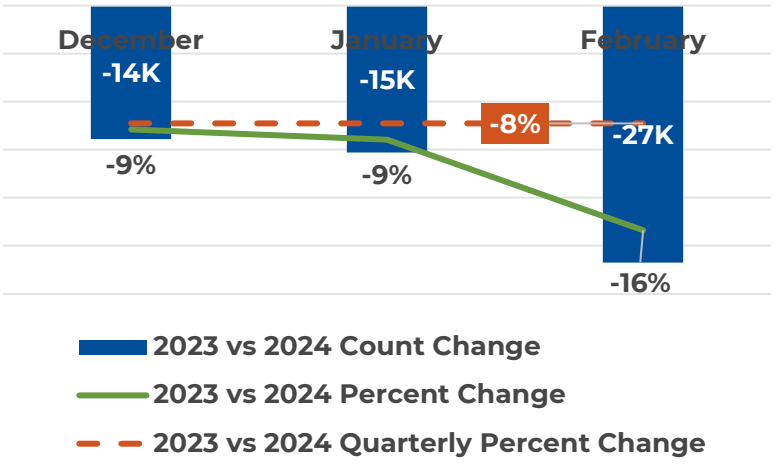




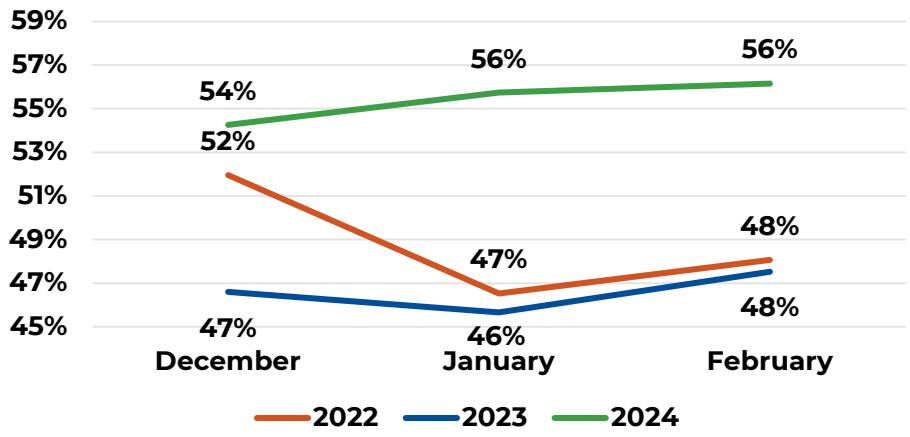
Enrollment & Utilization (Cont.)

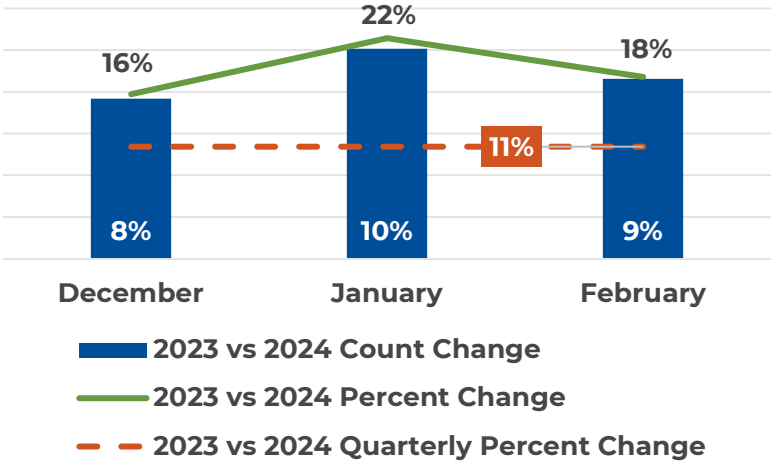
Expansion Utilization (Effective July 2021)





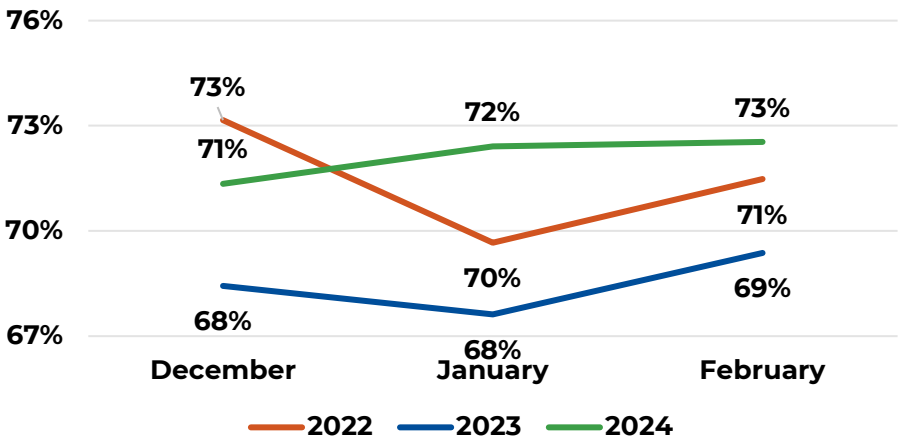
Percent of Total Enrolled Members Utilization

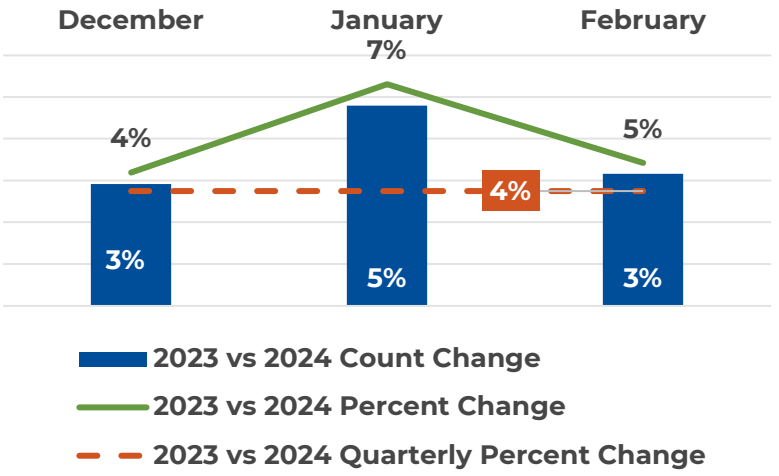




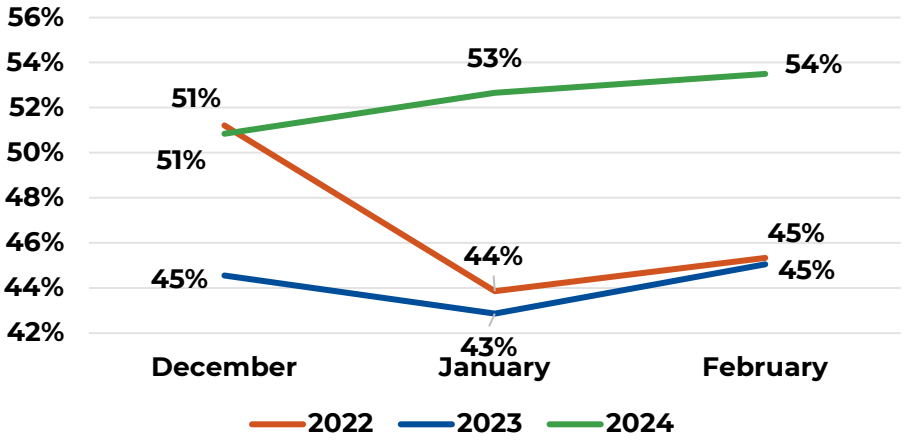
Enrollment & Utilization (Cont.)

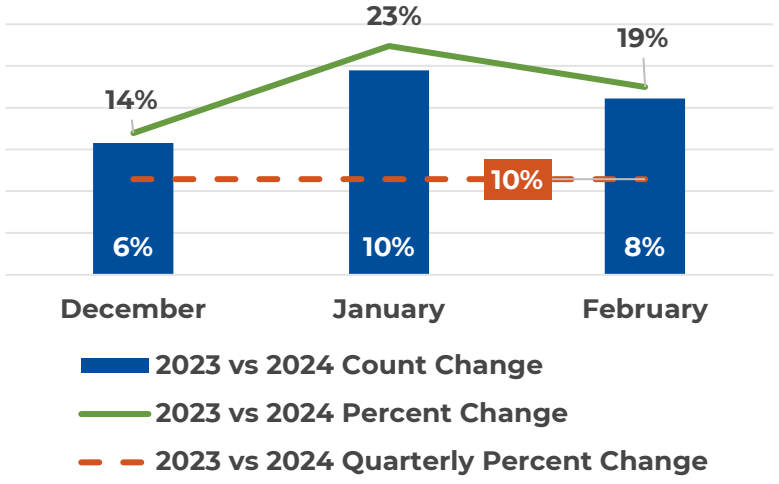
Percent of Aged/Blind/Disabled Enrolled Members Utilization





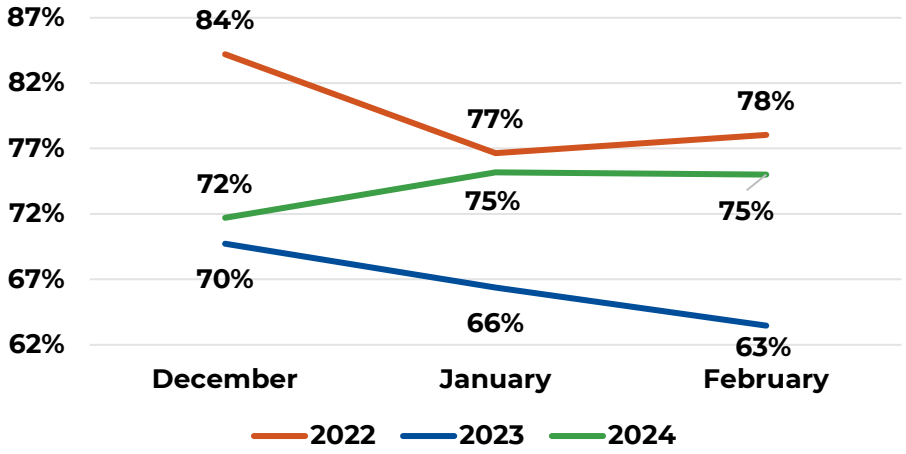
Percent of Children & Parent/Caretaker Enrolled Members Utilization

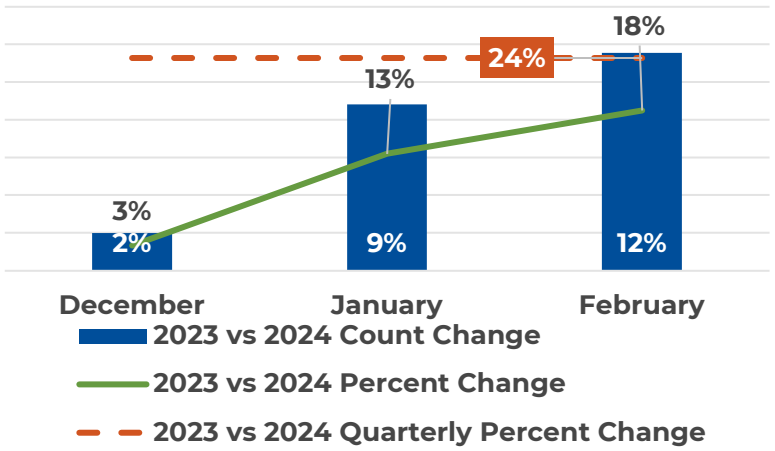




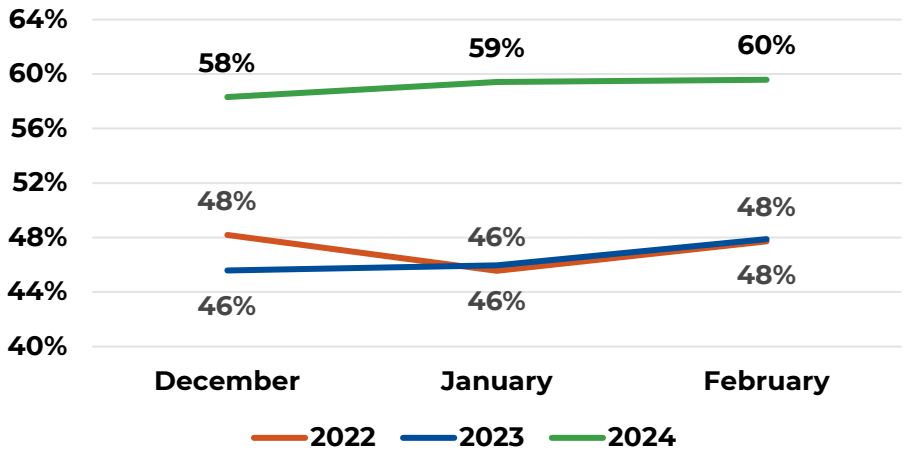
Enrollment & Utilization (Cont.)

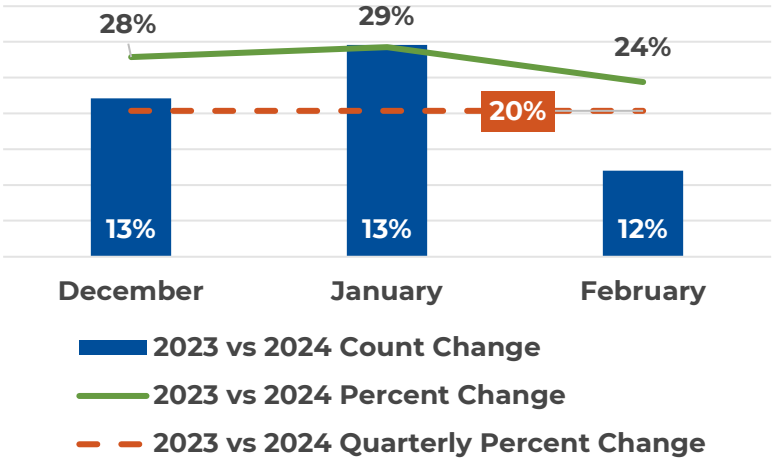
Percent of Pregnant (Full Scope) Enrolled Members Utilization





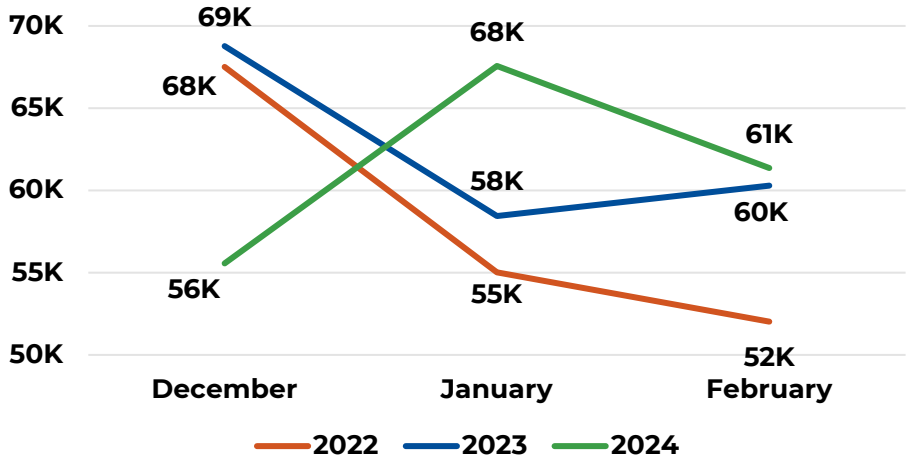
Percent of Expansion Enrolled Members Utilization (Effective July 2021)

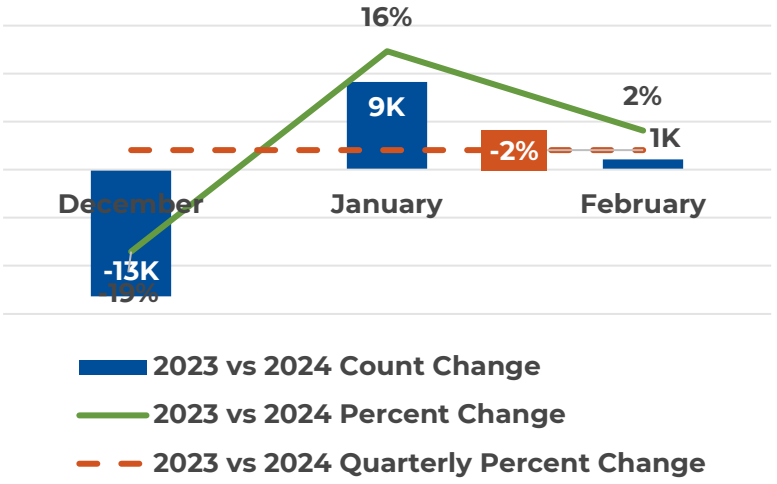




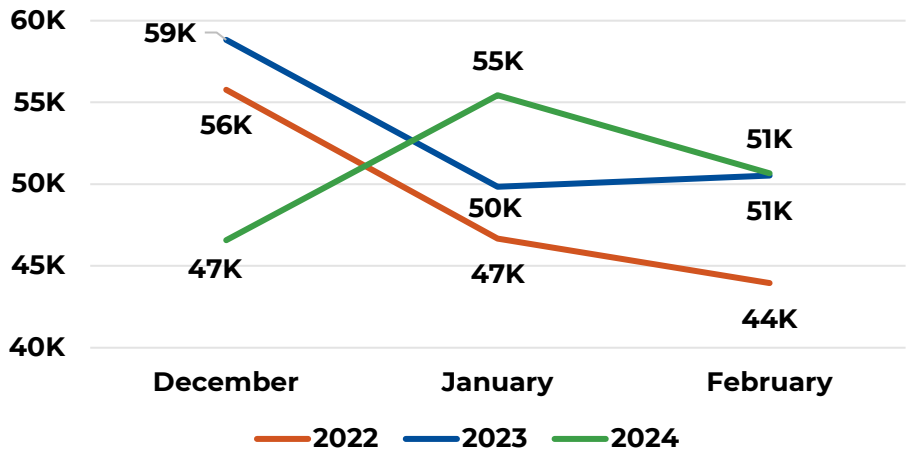
Utilization

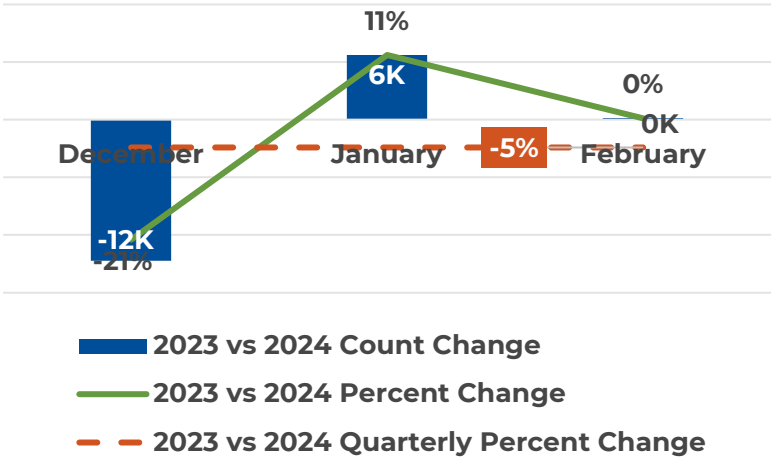
Emergency Department Visits (Claims)





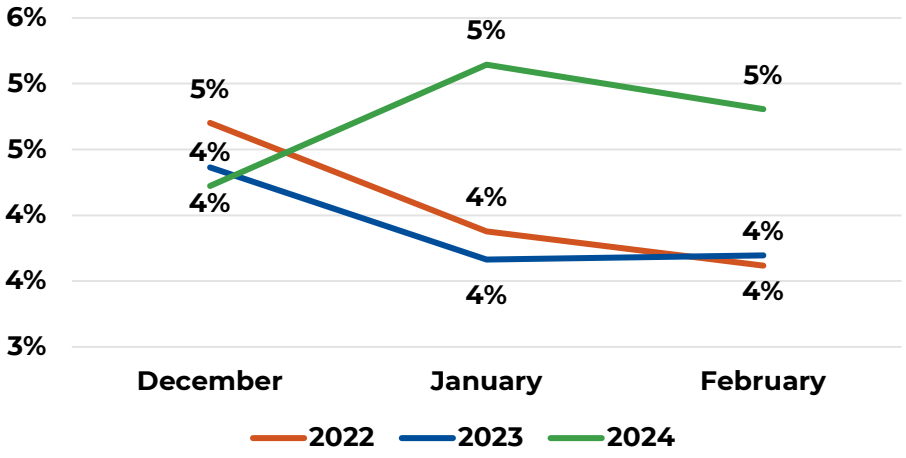
Members Utilizing Emergency Department

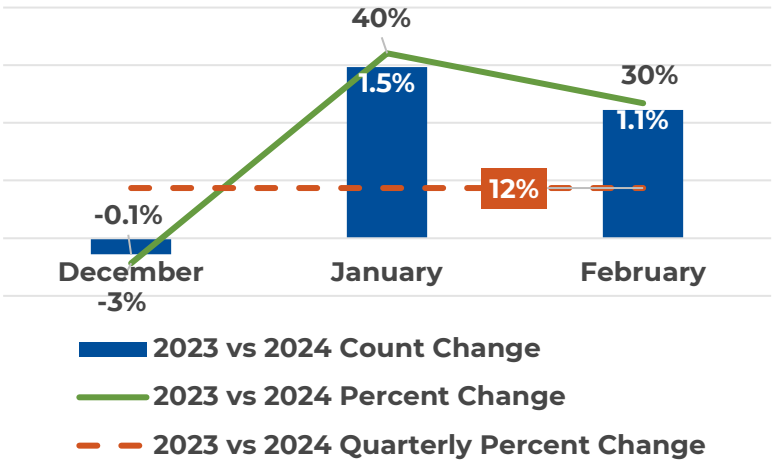




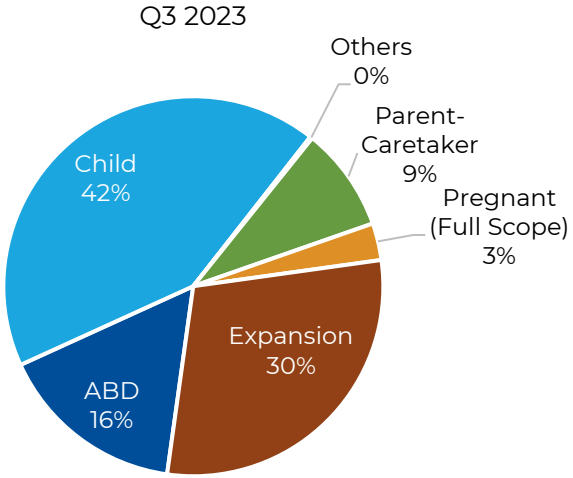
Utilization (Cont.)

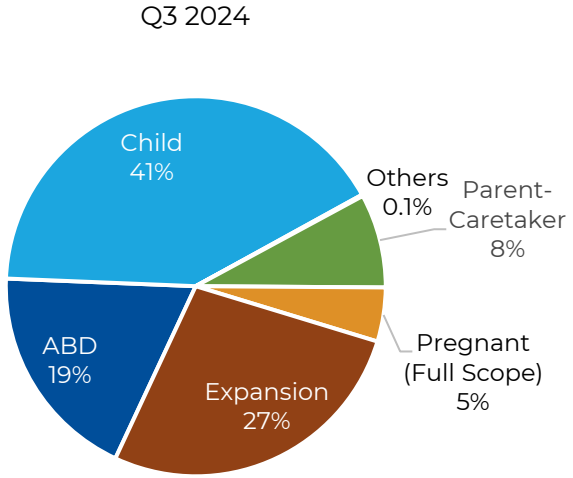
Percent Total Enrolled Using ED





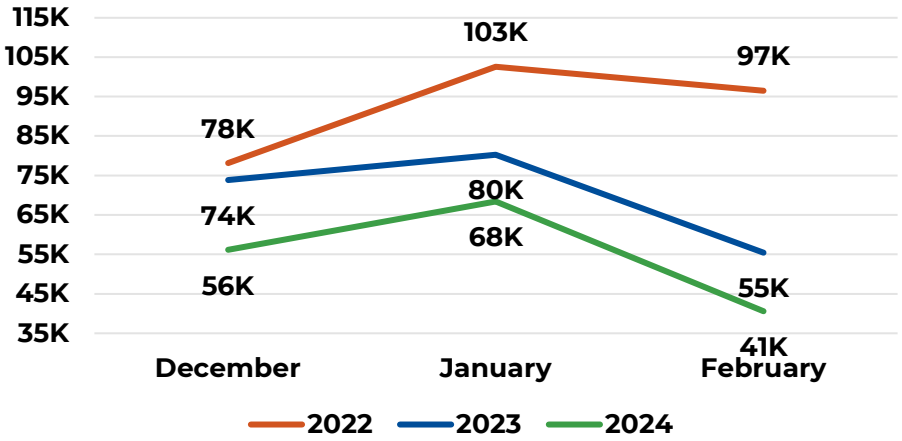
Members Utilizing Emergency Department By Qualifying Group

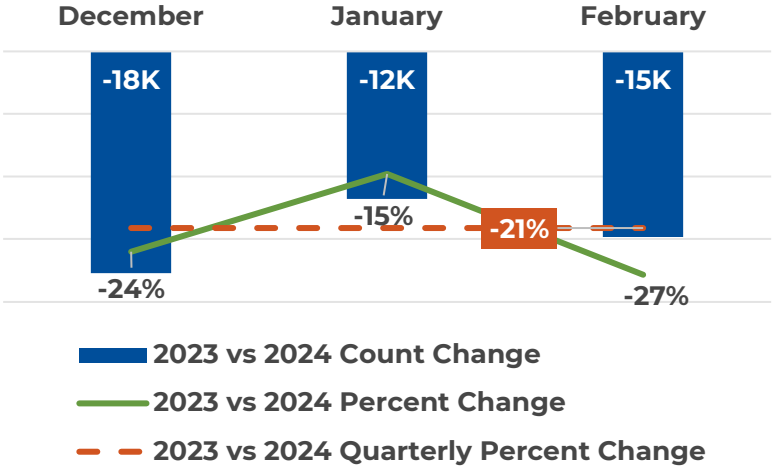




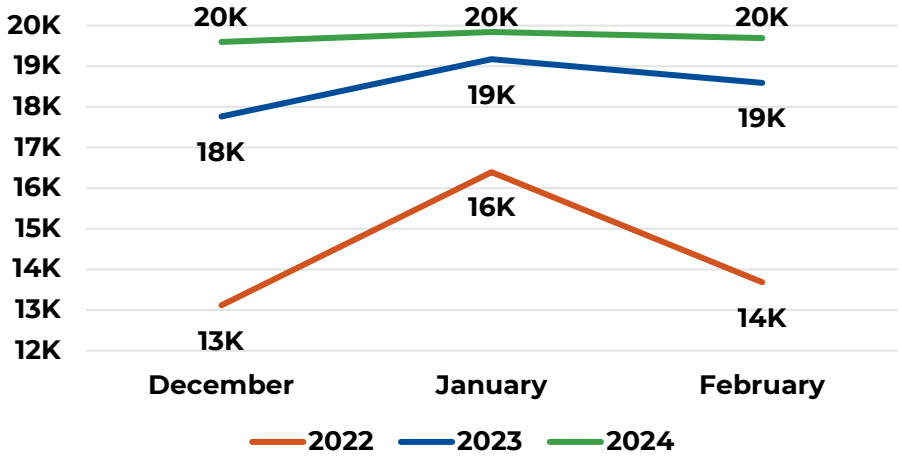
Utilization (Cont.)

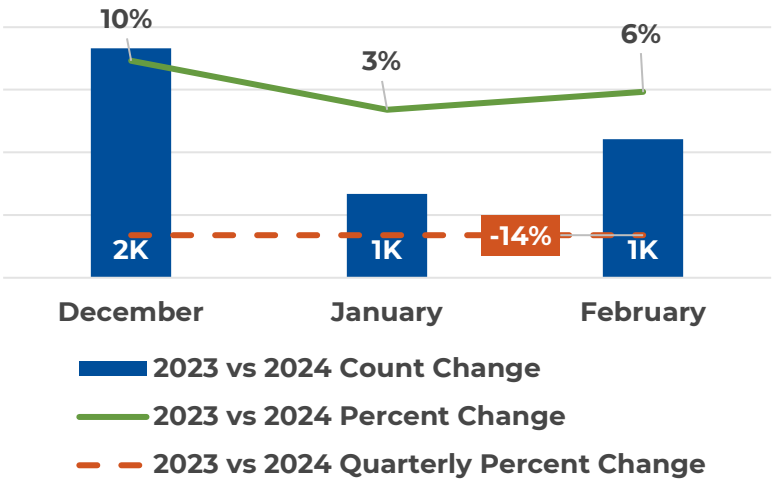
Telemedicine - Total Visits





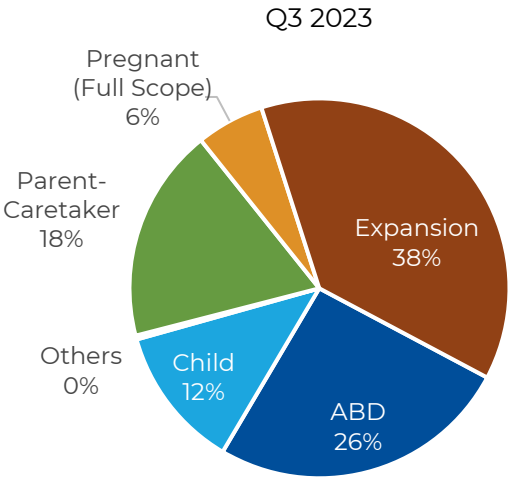
Members With Opioid Claims

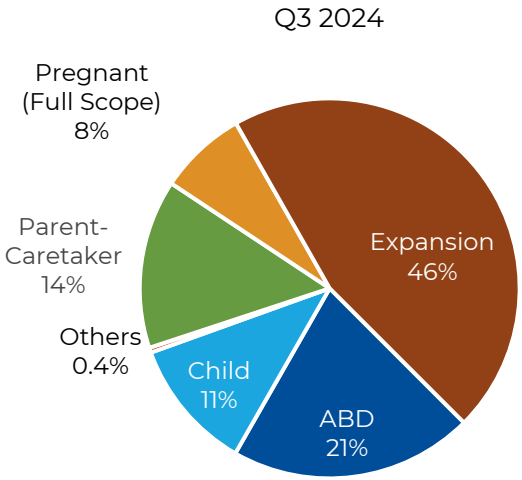




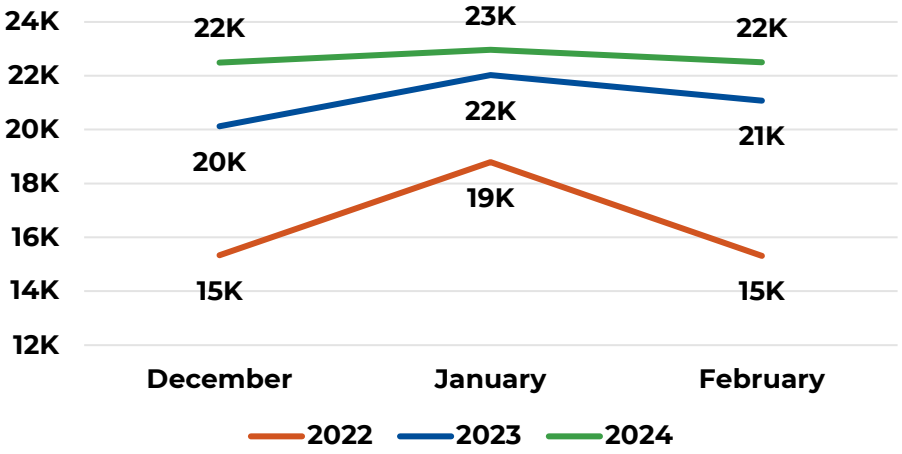
Utilization (Cont.)

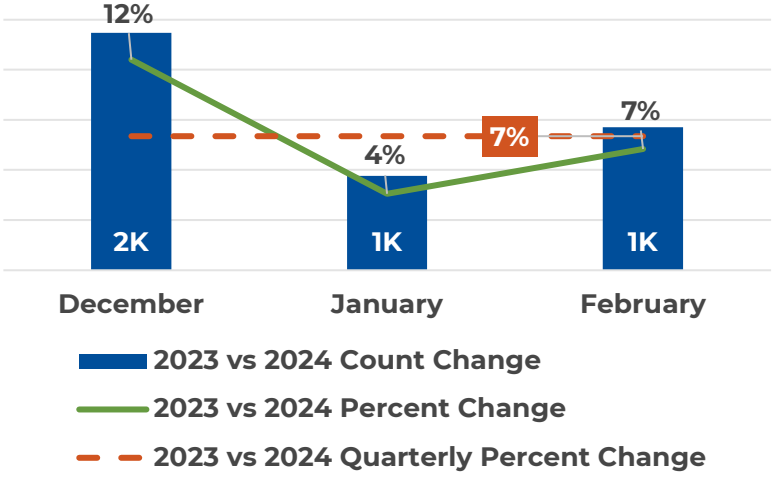
Members With Opioid Claims By Qualifying Group





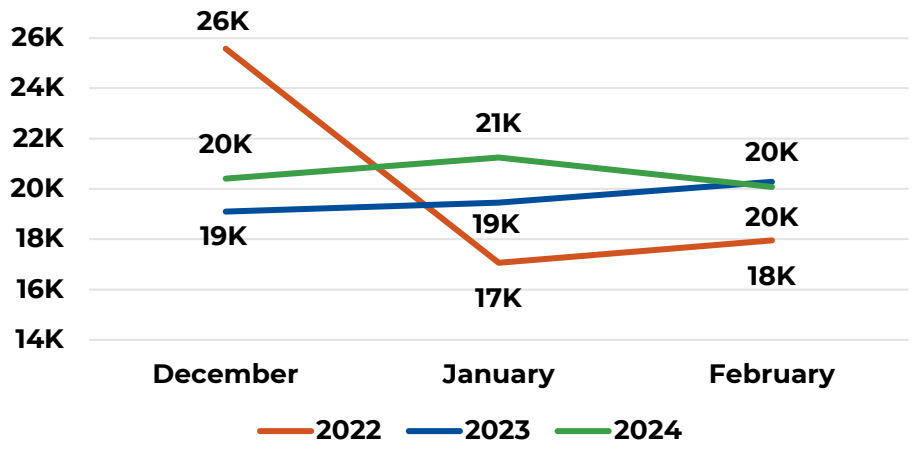
Total Opioid Claims

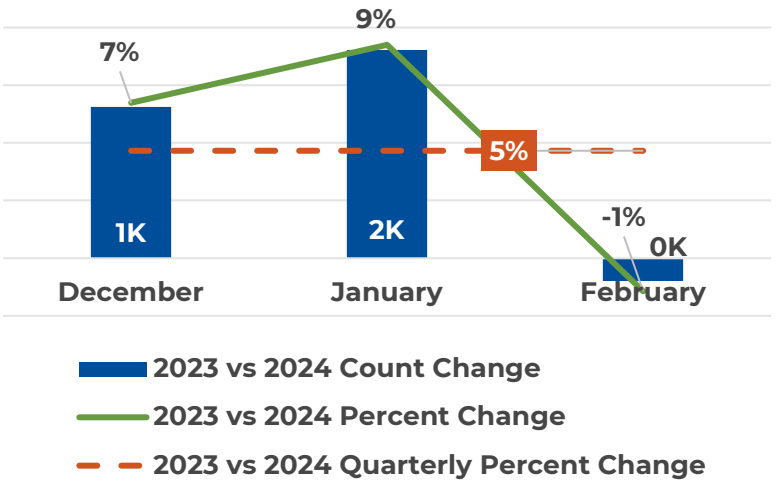




Utilization (Cont.)

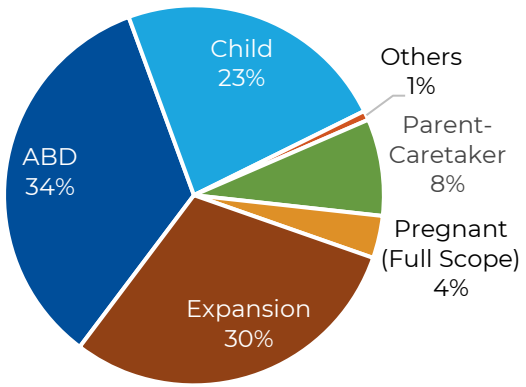
Out of State Services (Non Border County) - Total Members Utilization



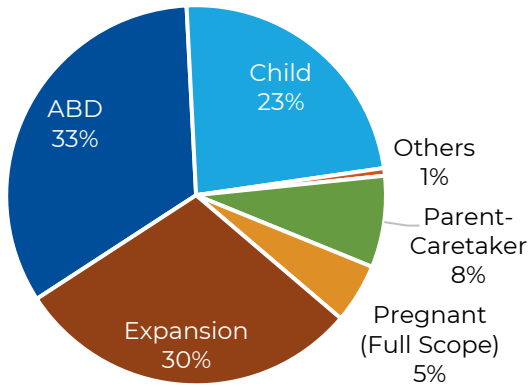


Out of State Services (Non Border County) - Total Members Utilization By Qualifying Group

Q3 2023

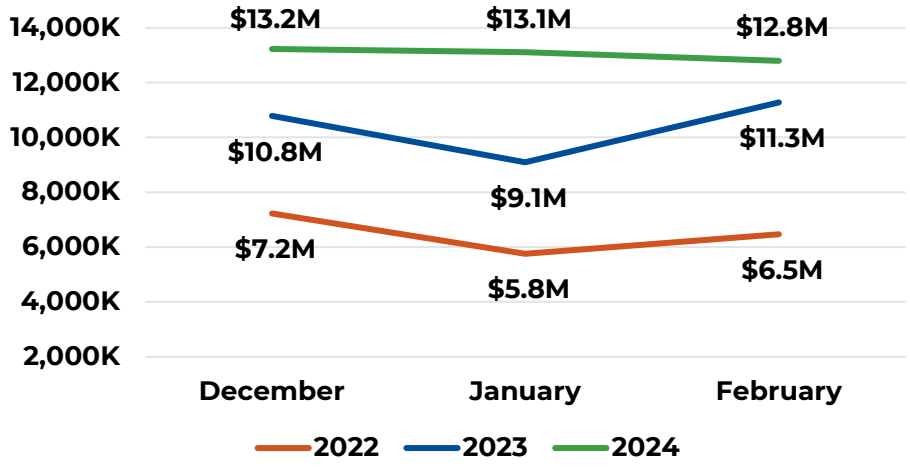


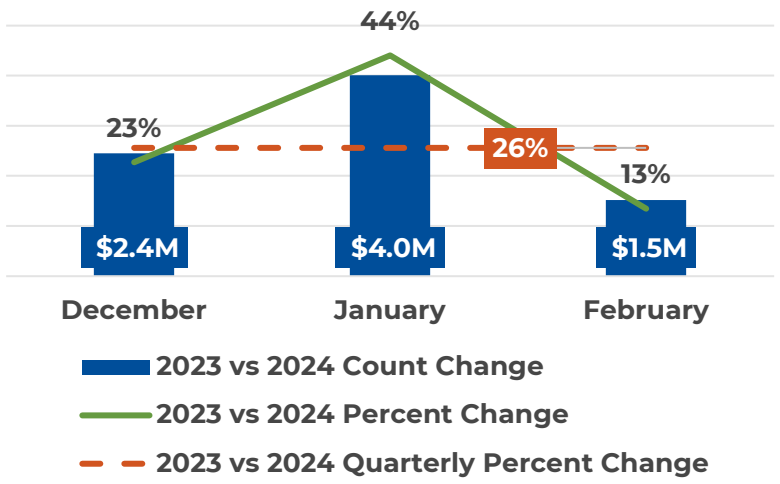
Q3 2024



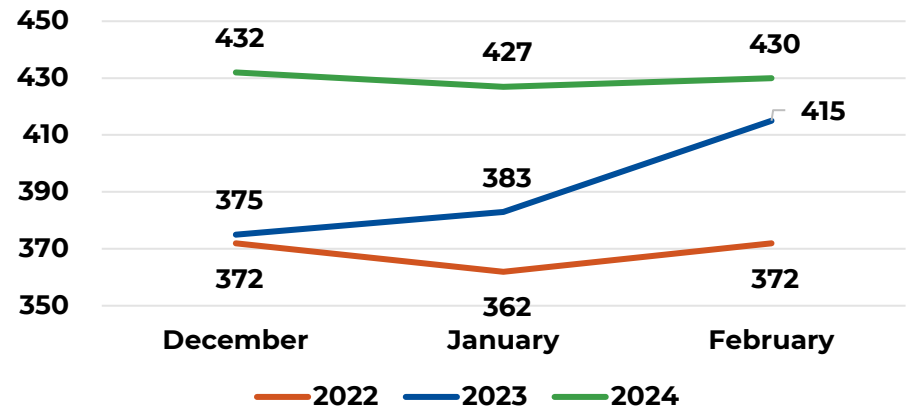
Utilization (Cont.)

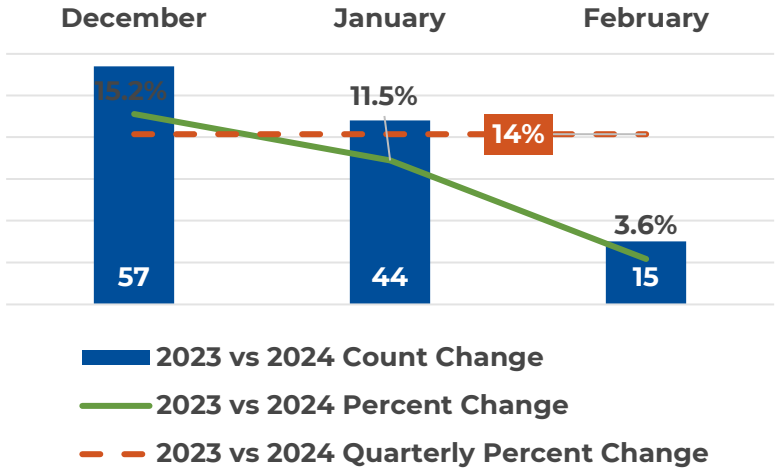
Out of State Services (Non Border County) - Total Reimbursements





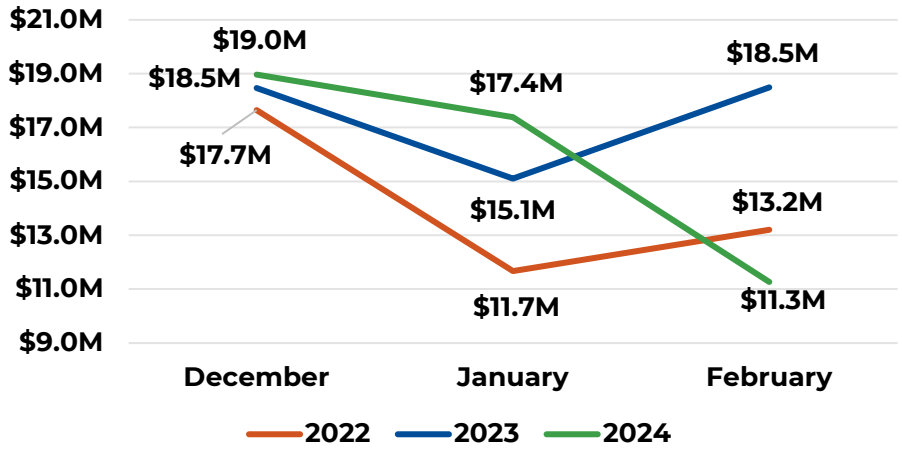
Out of State Services (Non Border County) - Total Active Billing Providers

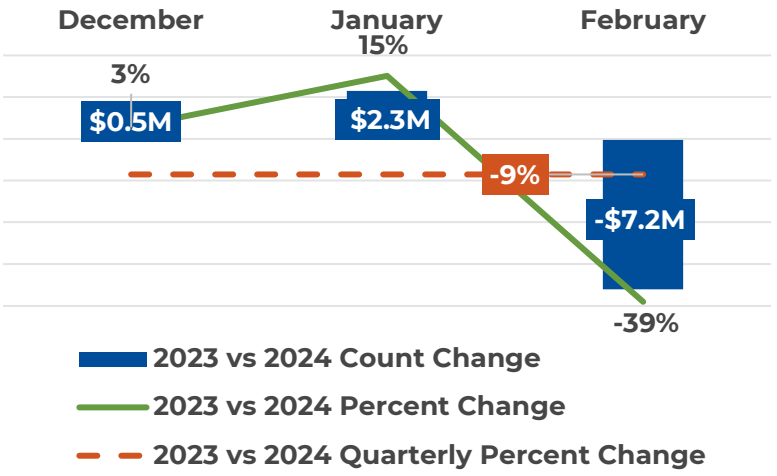




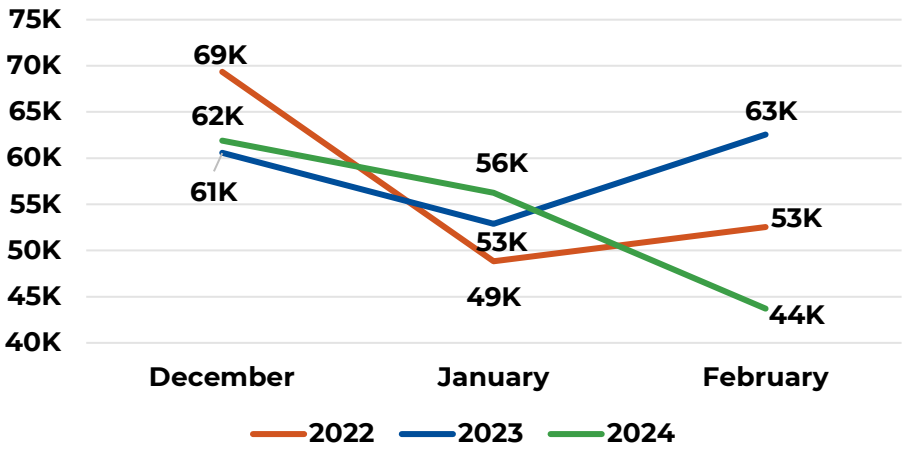
Utilization (Cont.)

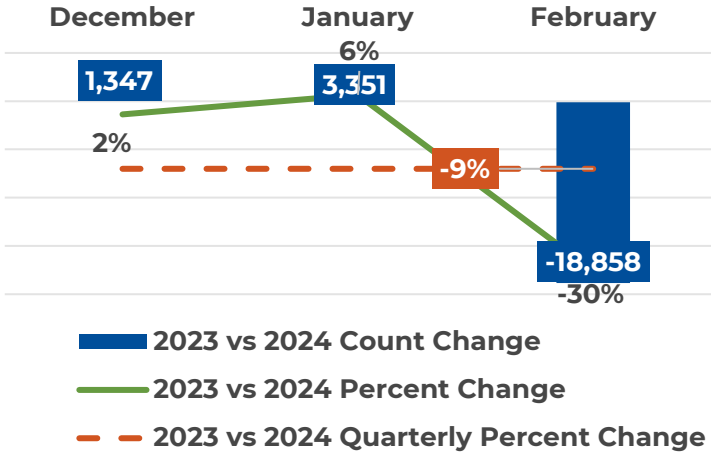
Dental Claims





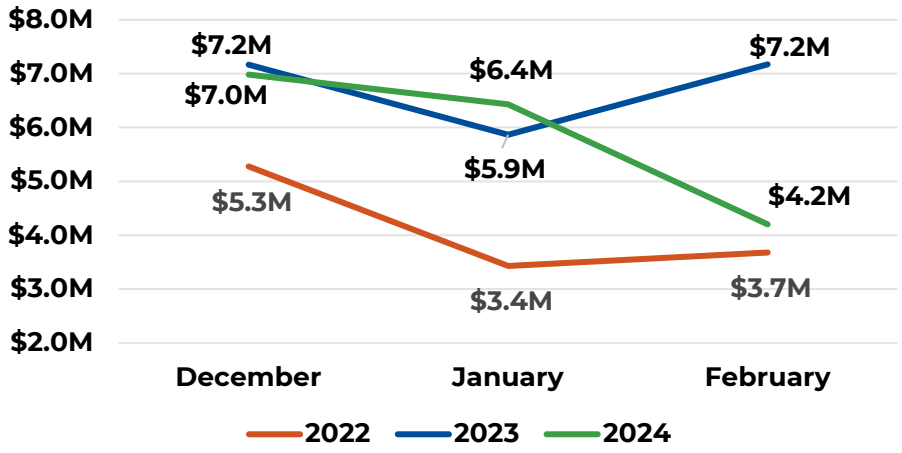
Total Members with Dental Claims

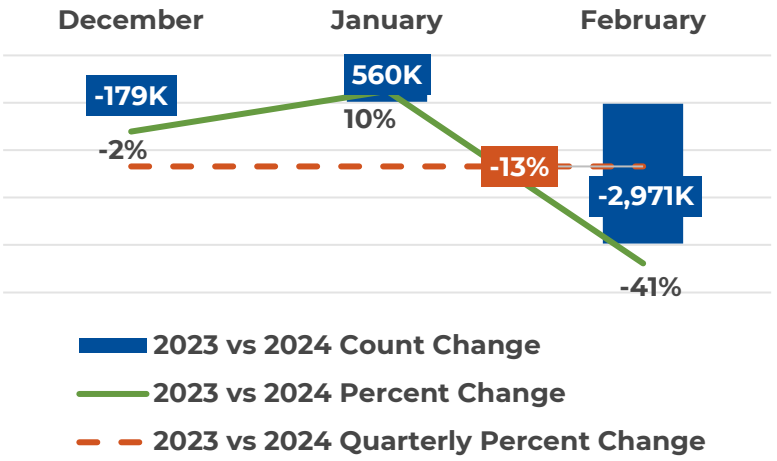




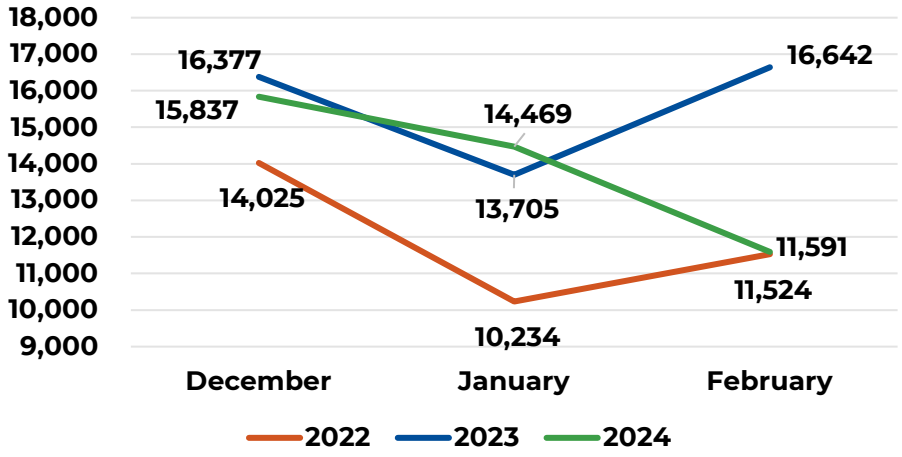
Utilization (Cont.)

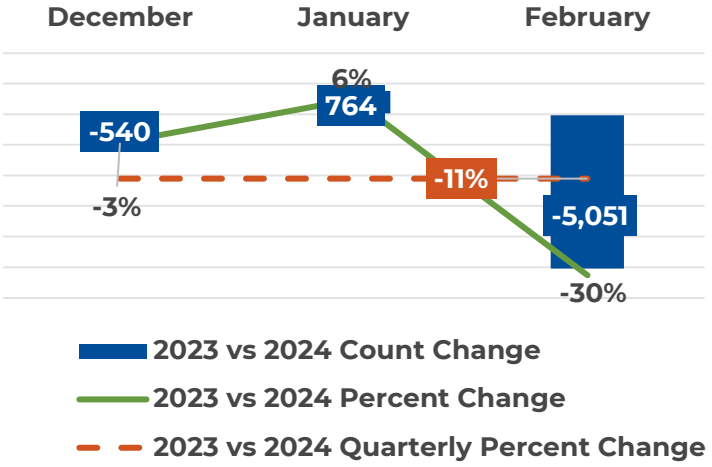
Adult (21 & Over) Dental Claims





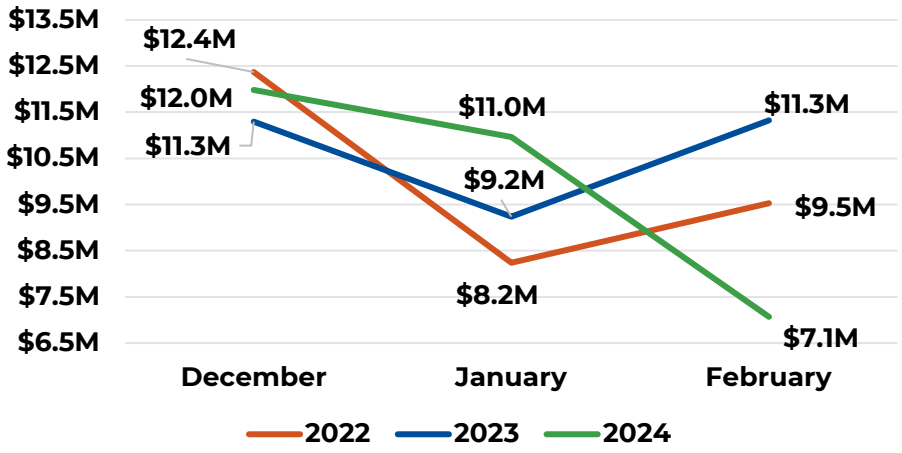
Adults (21 & Over) with Dental Claims

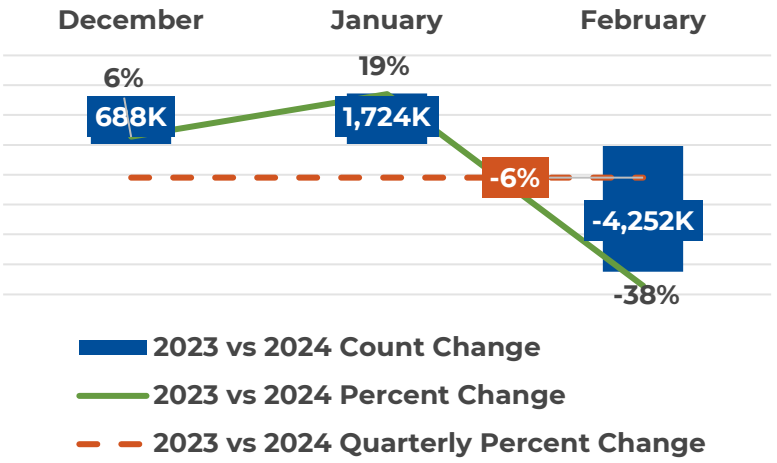




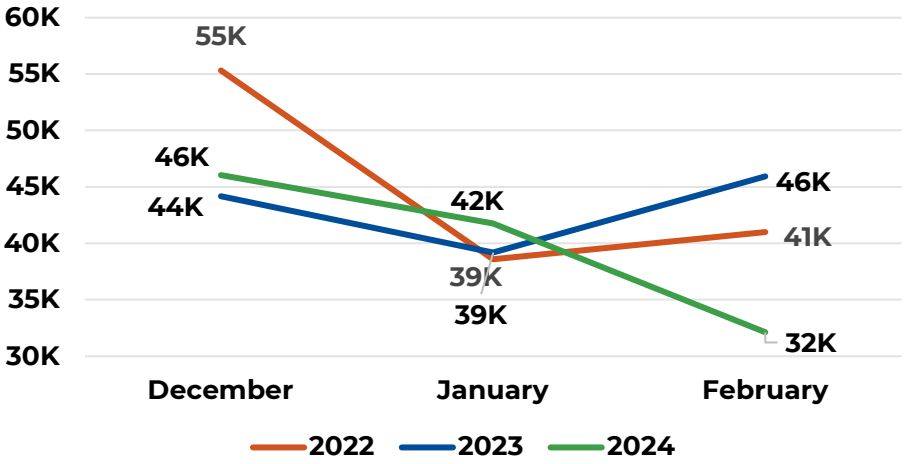
Utilization (Cont.)

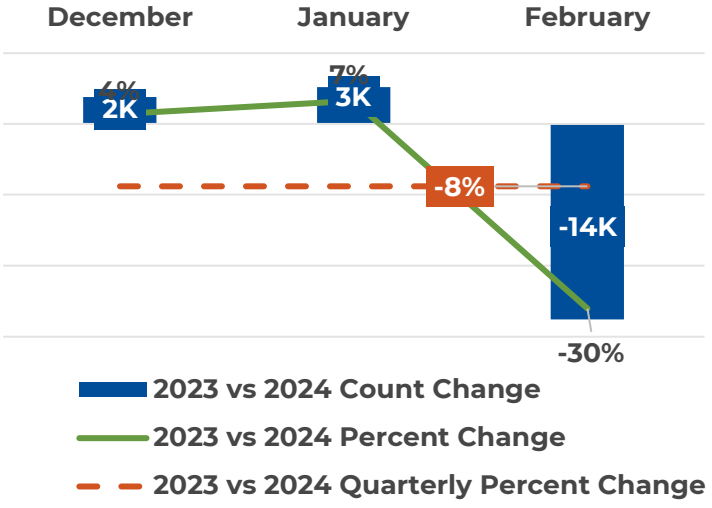
Children (Under 21) Dental Claims





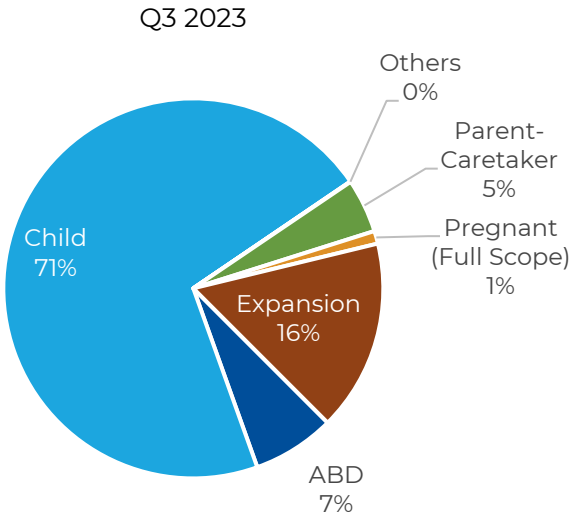
Children (Under 21) with Dental Claims

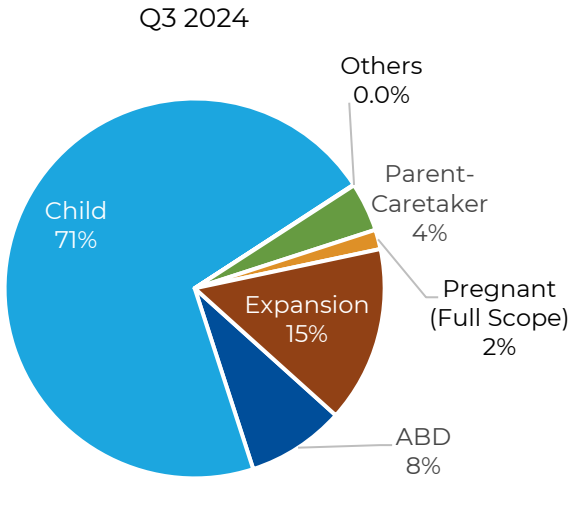




Utilization (Cont.)

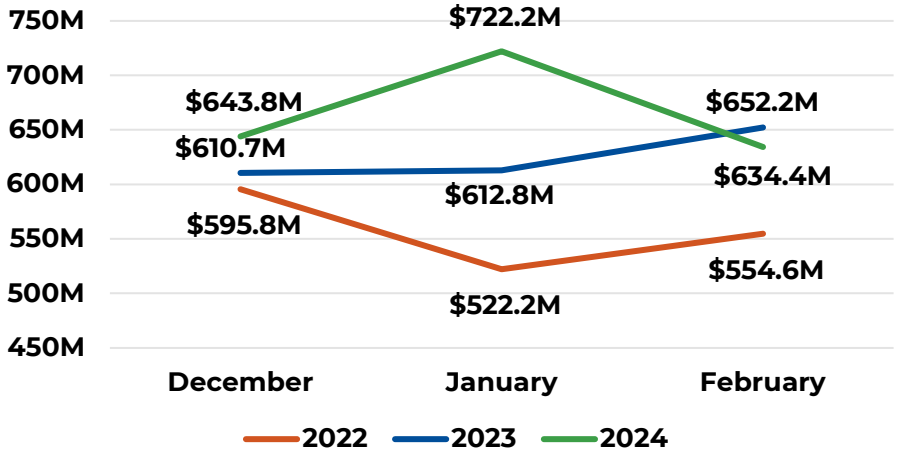
Members With Dental Claims By Qualifying Group

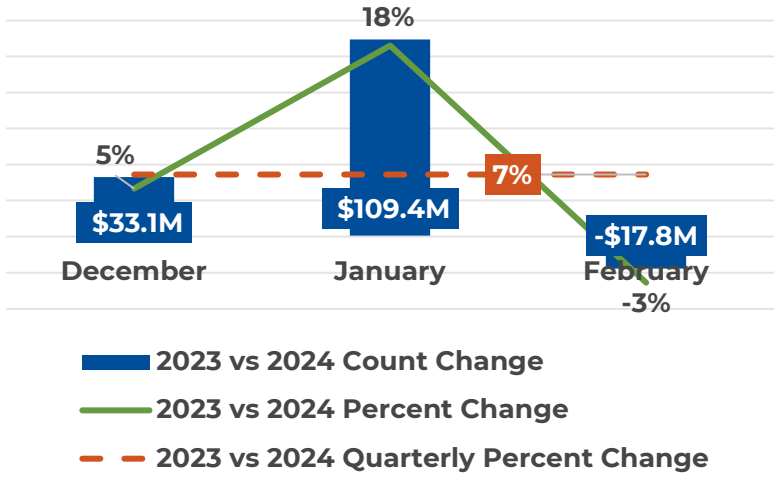




Financials

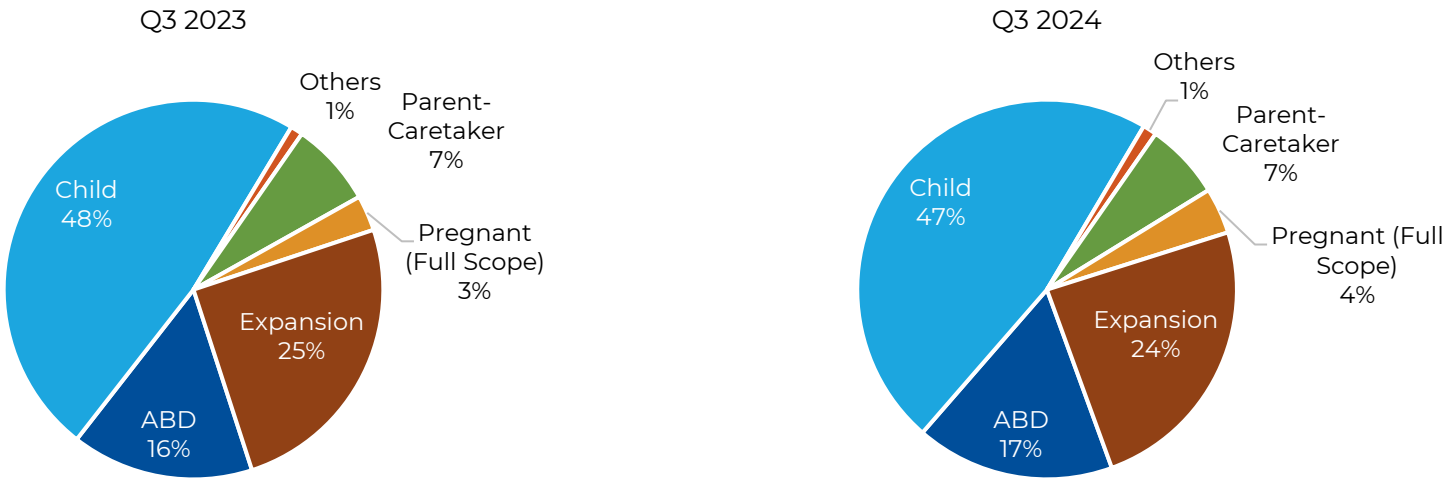
Total Agency Expenditures



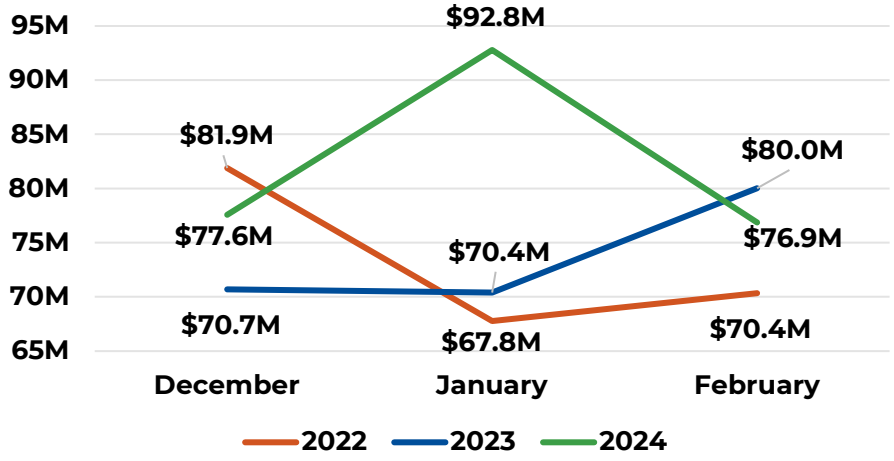


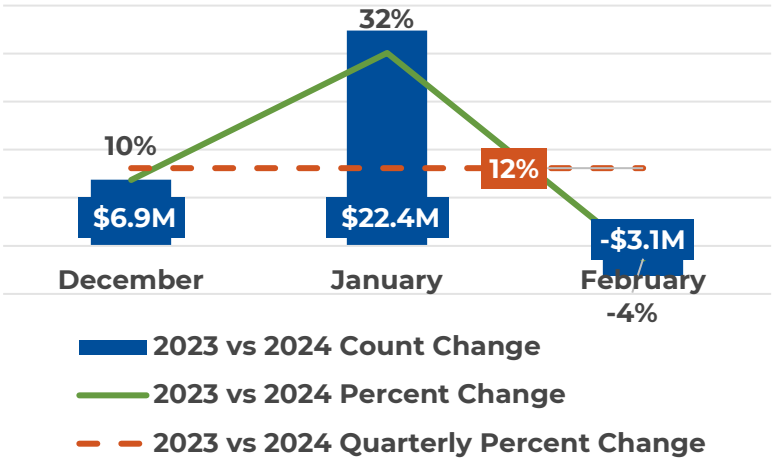
Financials (Cont.)

Total Agency Members Utilization by Qualifying Group



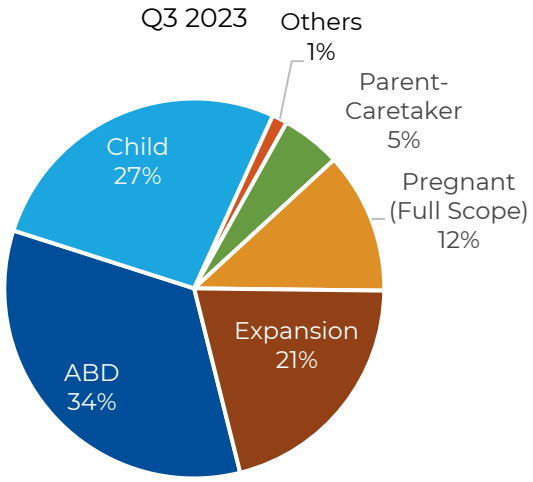
Inpatient Services Expenditures

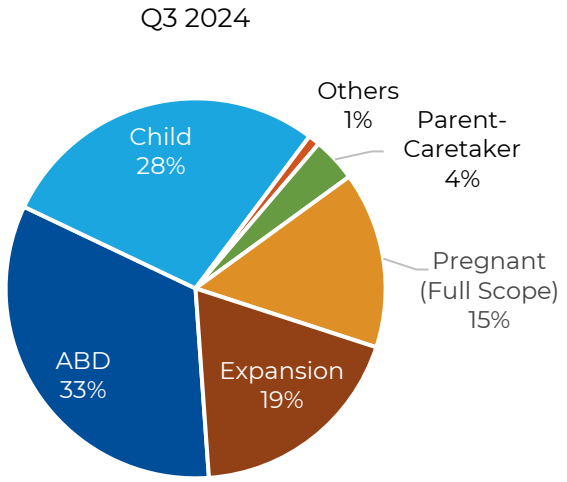




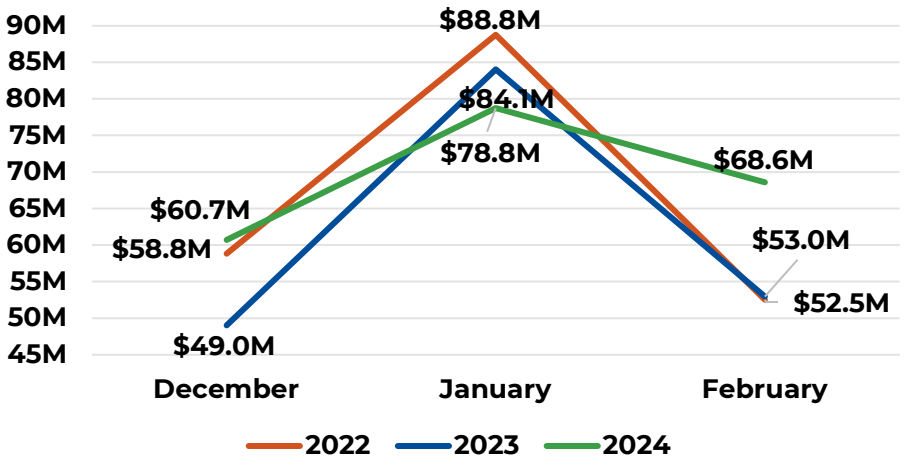
Financials (Cont.)

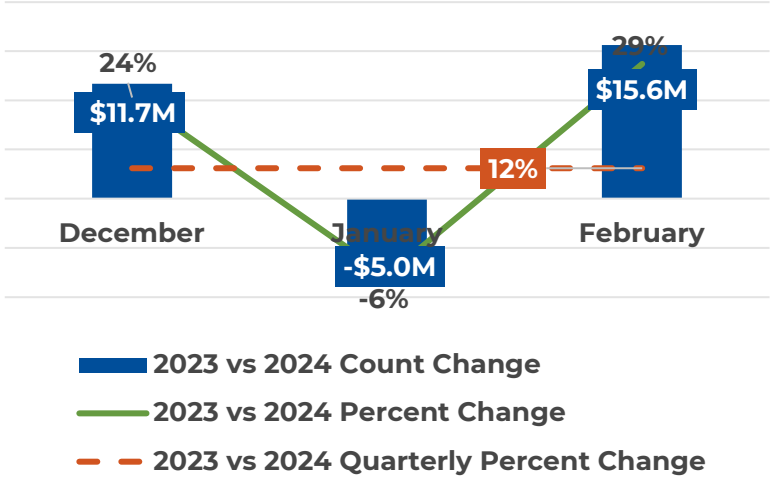
Inpatient Services Members Utilization by Qualifying Group





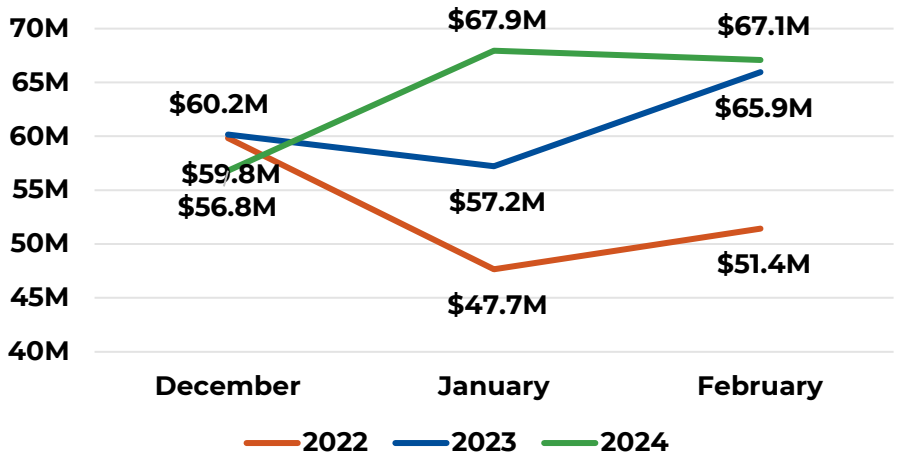
Nursing Facility Expenditures

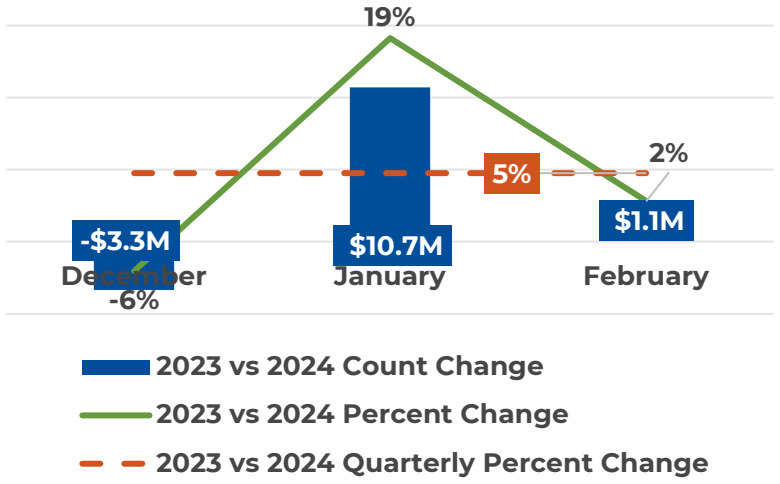




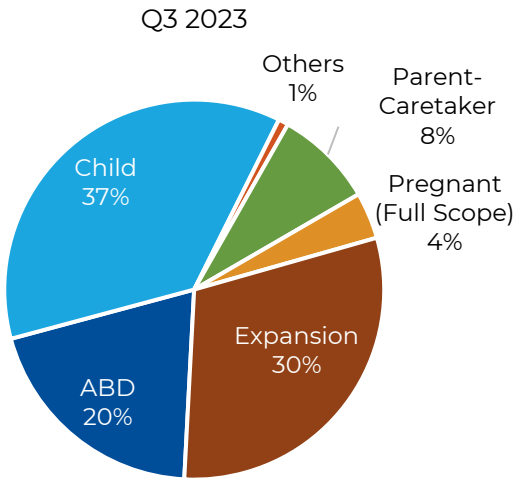
Financials (Cont.)

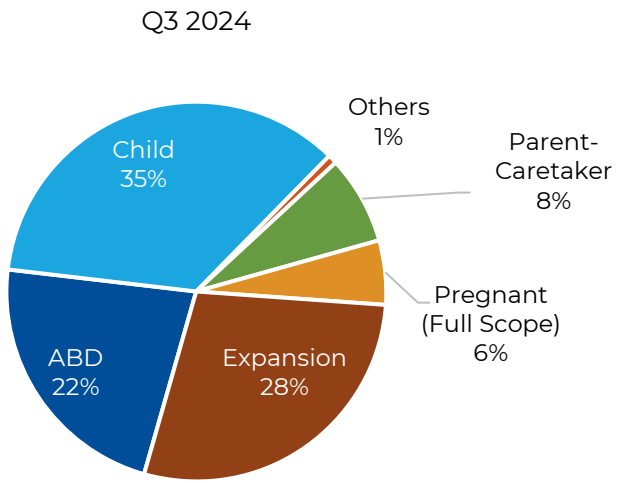
Outpatient Hospital Expenditures





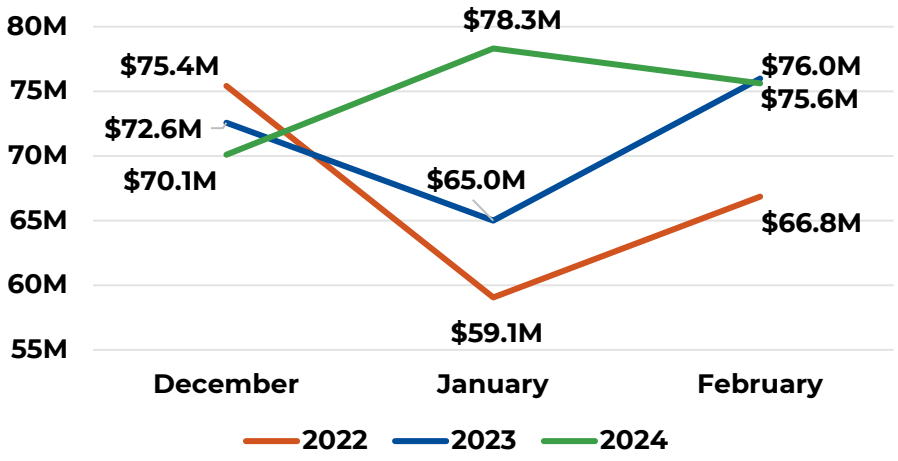
Outpatient Hospital Members Utilization by Qualifying Group

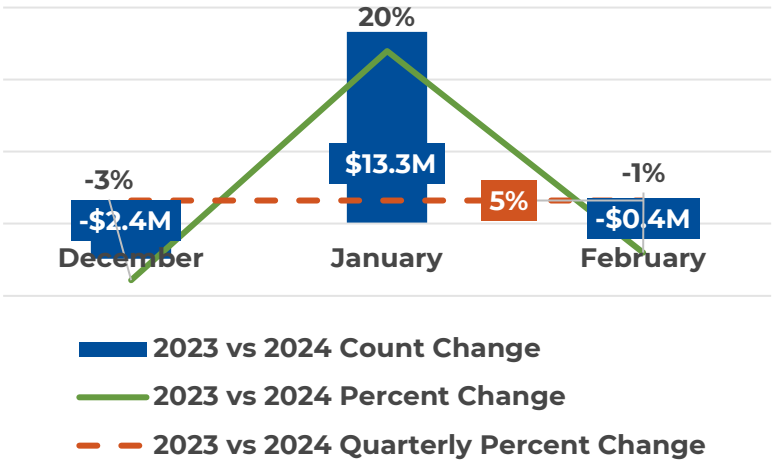




Financials (Cont.)

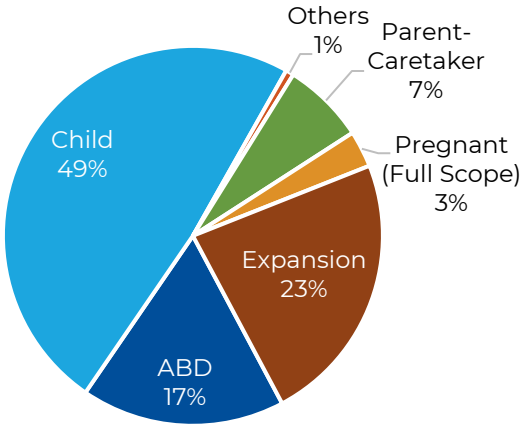
Physician Expenditures



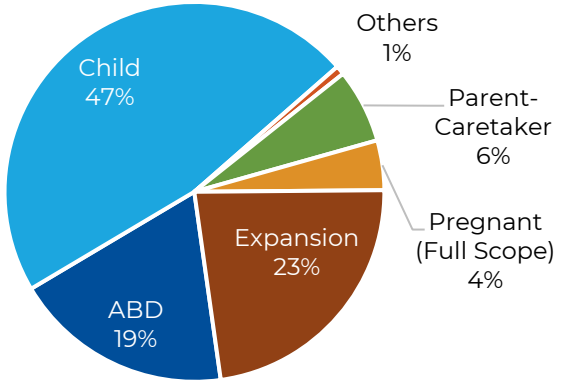


Physician Members Utilization By Qualifying Group

Q3 2023

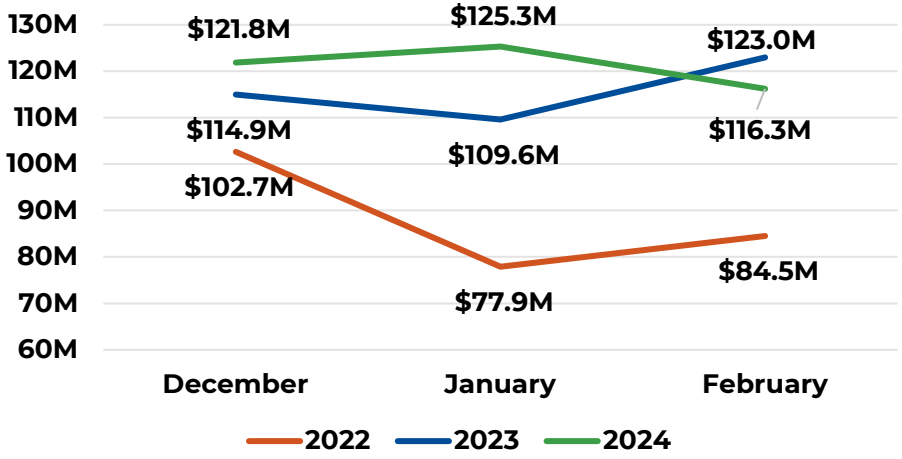


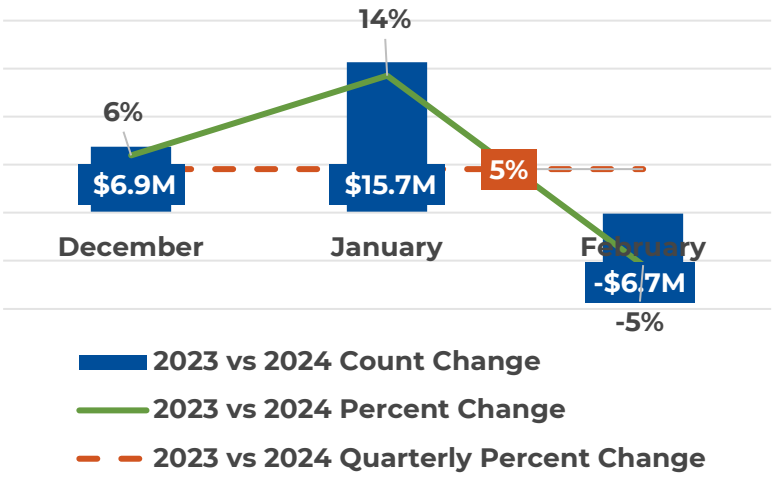
Q3 2024



Financials (Cont.)

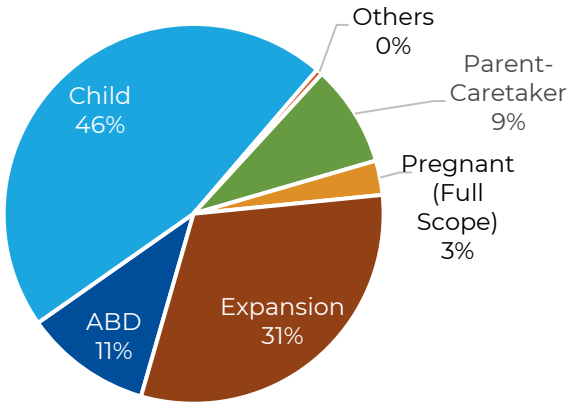
Prescribed Drugs Expenditures



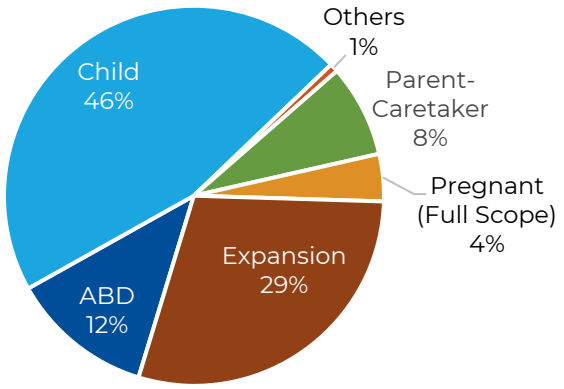


Prescribed Drugs Members Utilization By Qualifying Group

Q3 2023

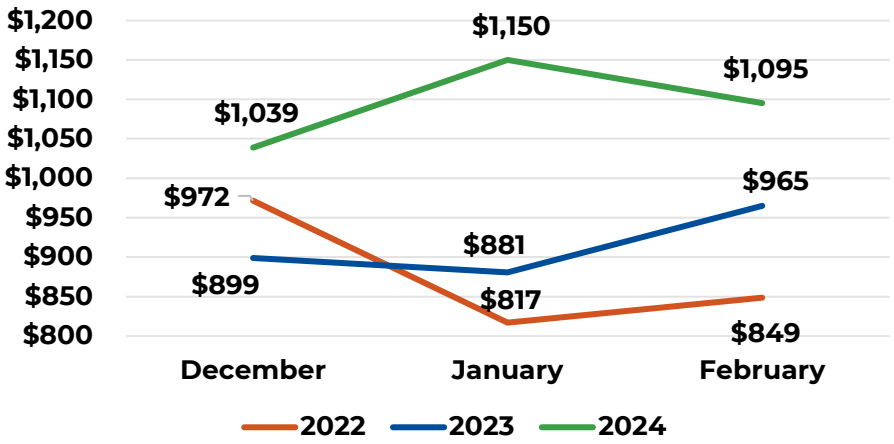


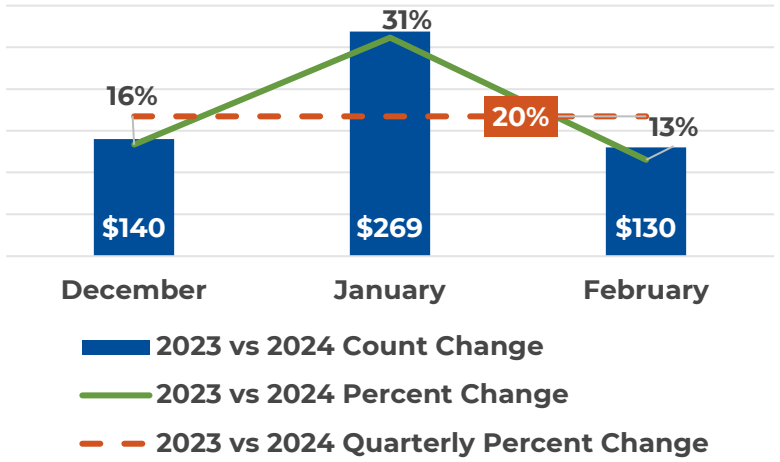
Q3 2024



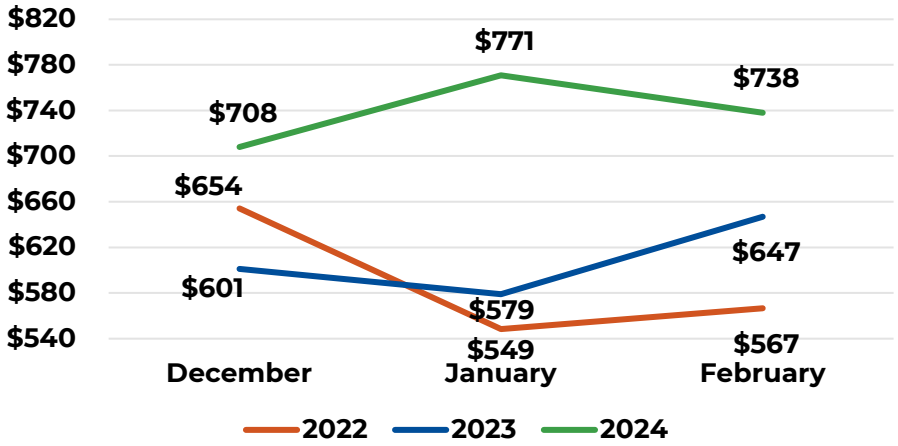
Financials (Cont.)

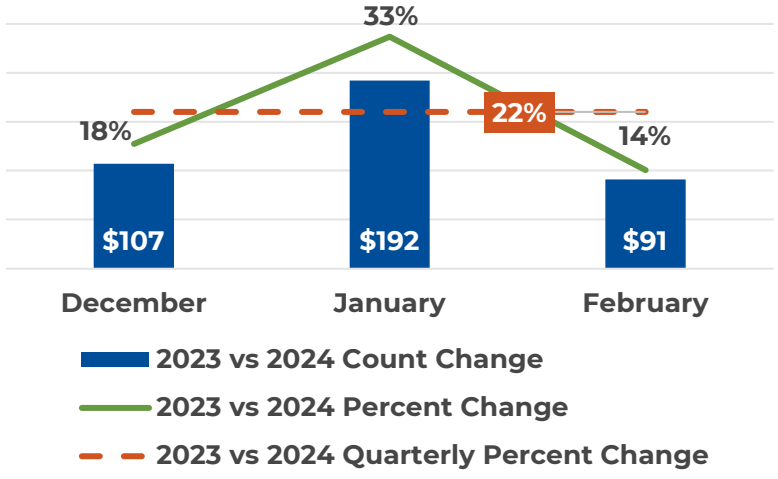
Average Per Total Member Served





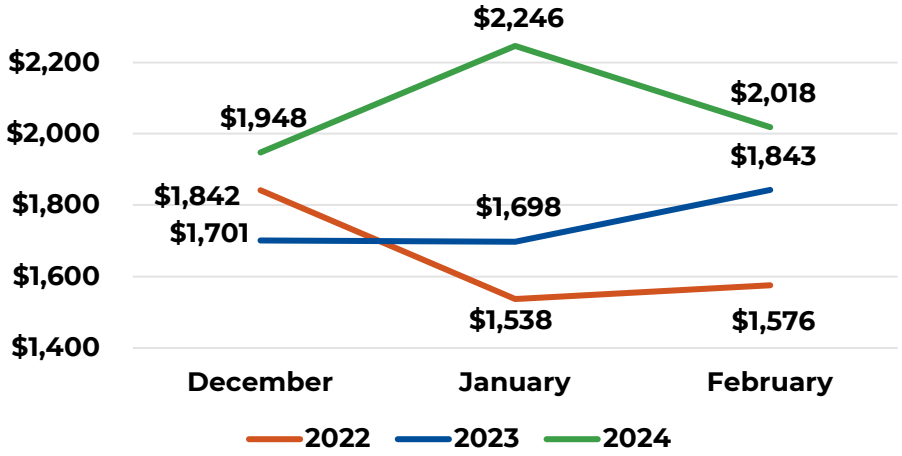
Average Per Child (Under 21) Member Served

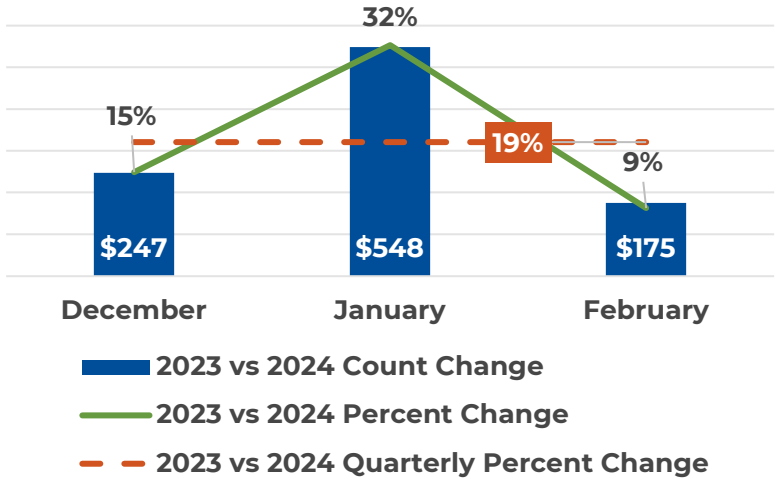




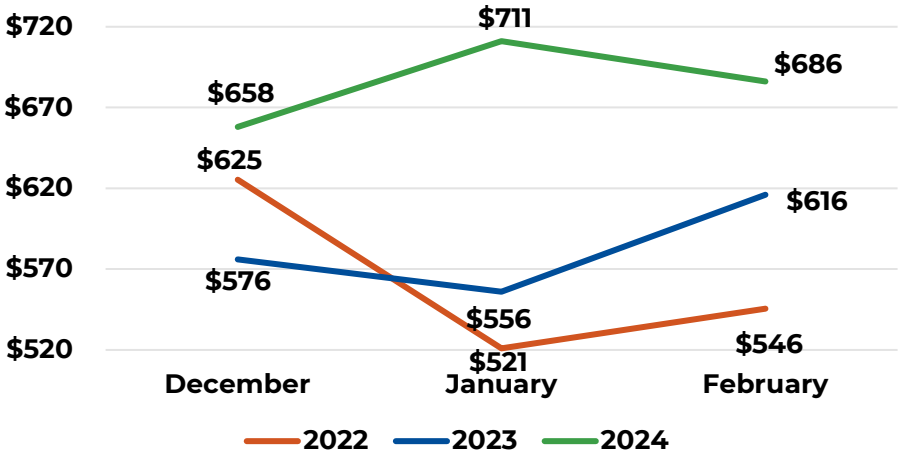
Financials (Cont.)

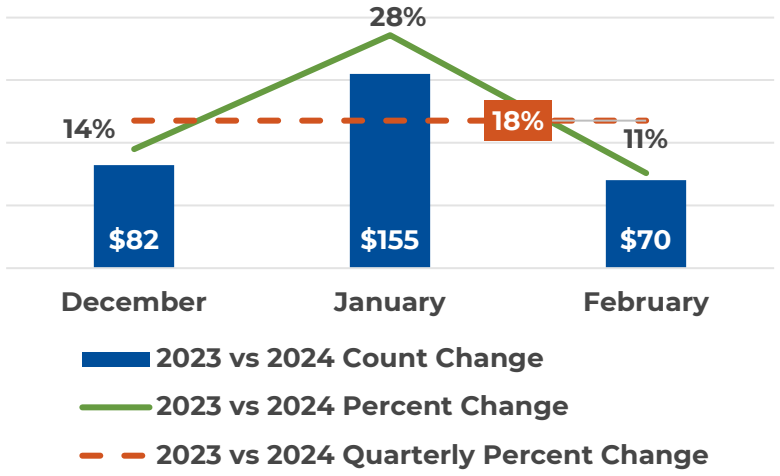
Average Per Aged/Blind/Disabled Member Served





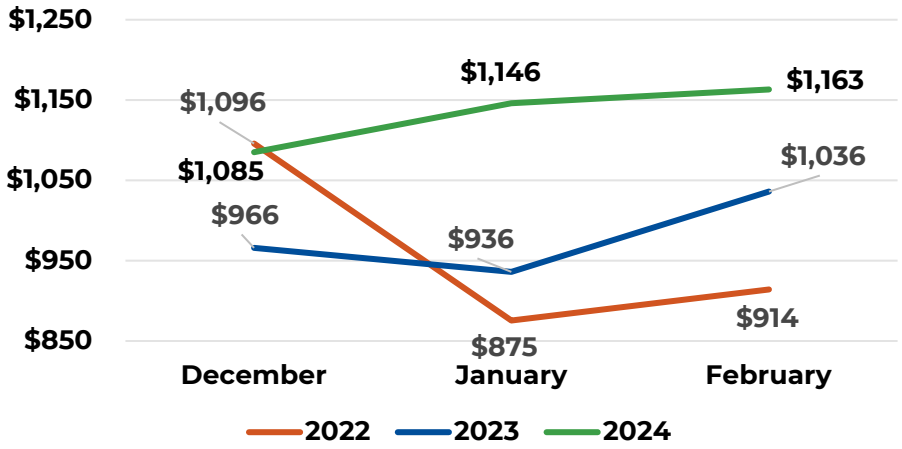
Average Per Children & Parent/Caretaker Member Served

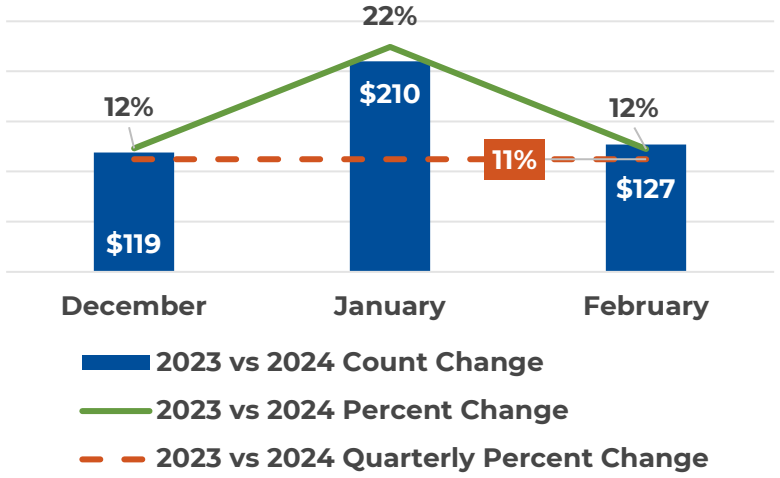




Financials (Cont.)

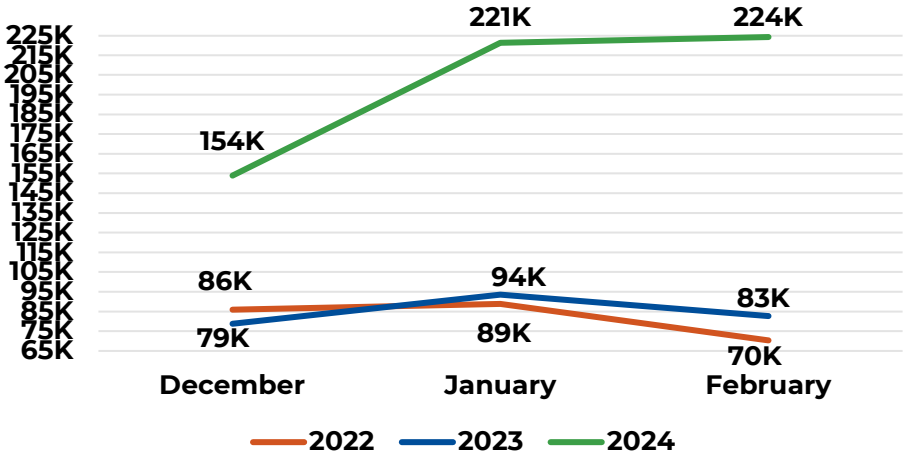
Average Per Expansion Member Served (Effective July 2021)

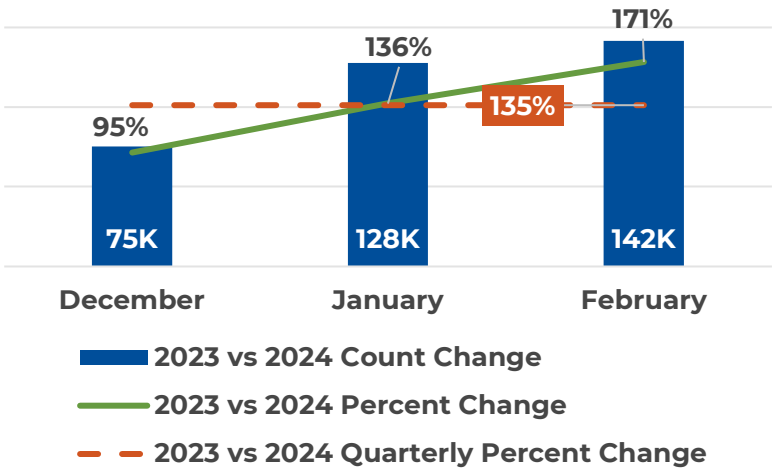




Call Center

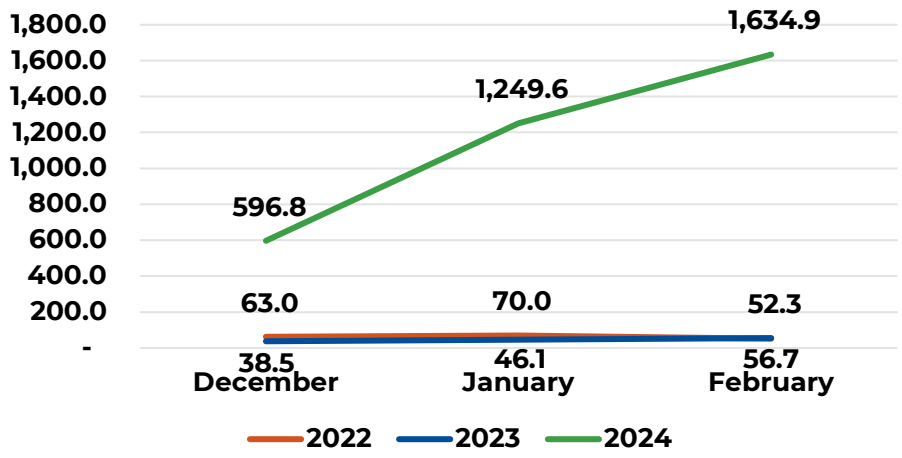
Call Center - Member Calls Answered

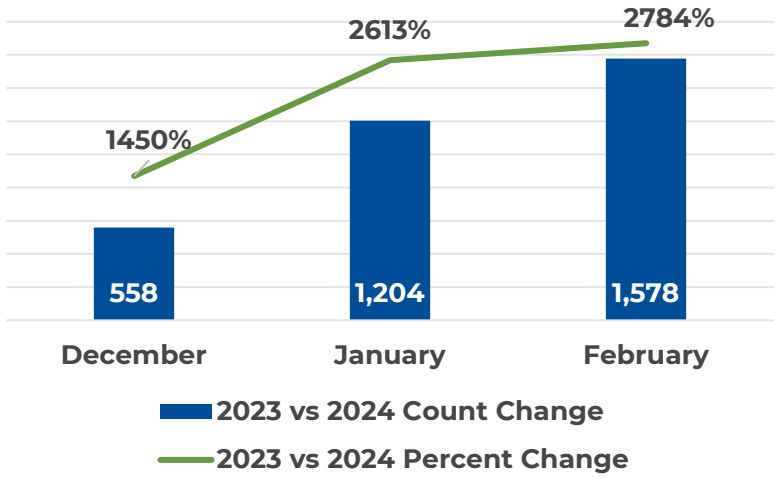




Call Center (Cont.)

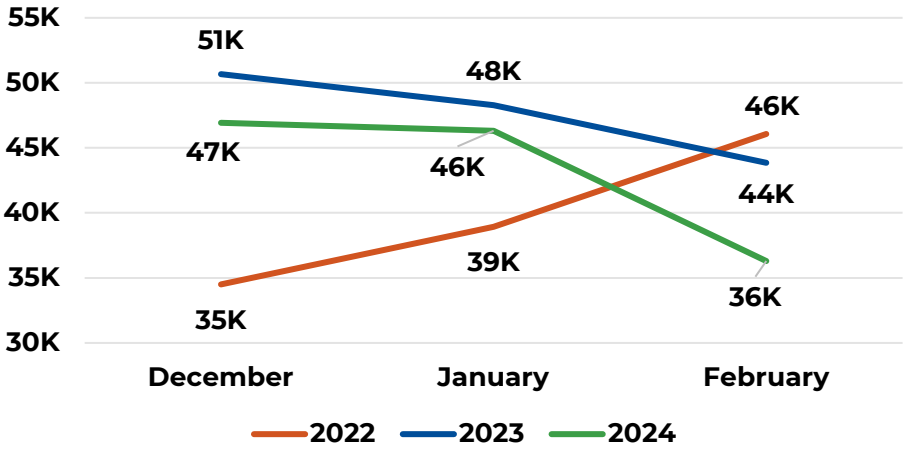
Call Center - Average Wait Time (In Seconds)

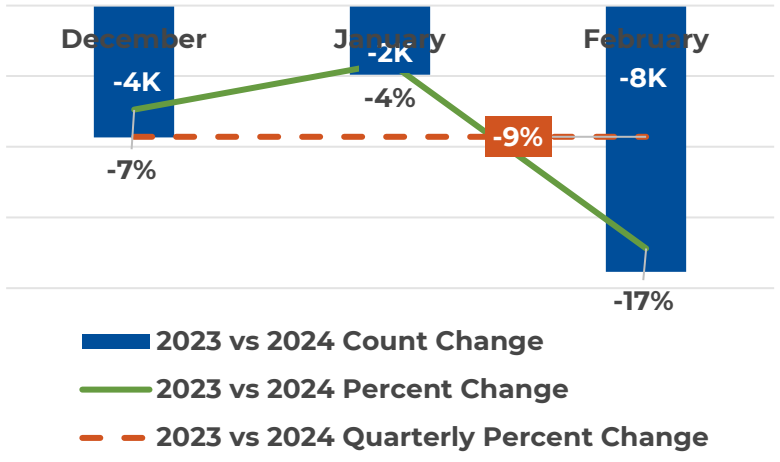




Prior Authorization

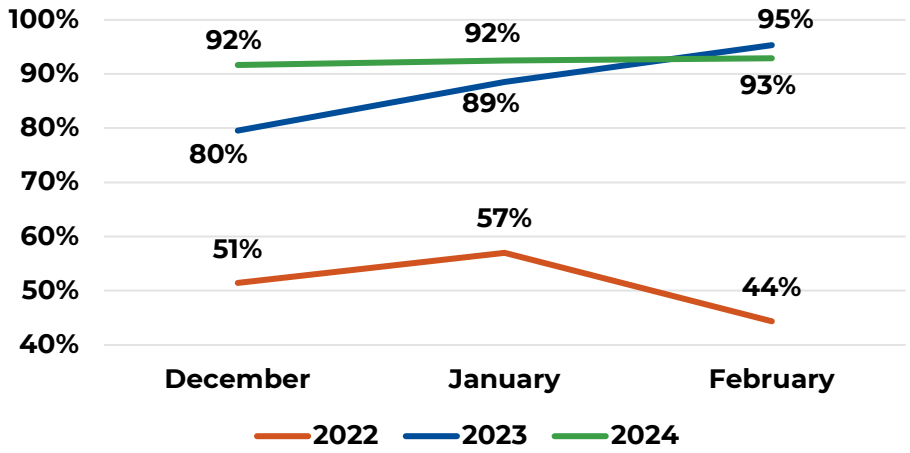
Prior Authorization - Total Combined - Total Completed PA Volume

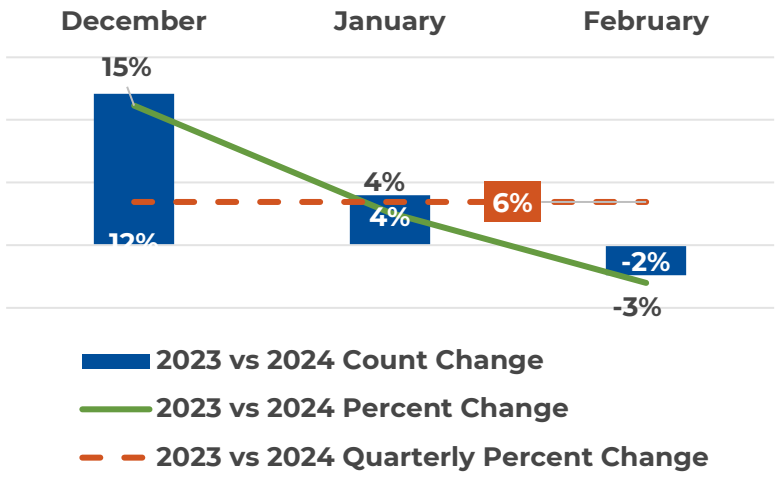




Prior Authorization (Cont.)

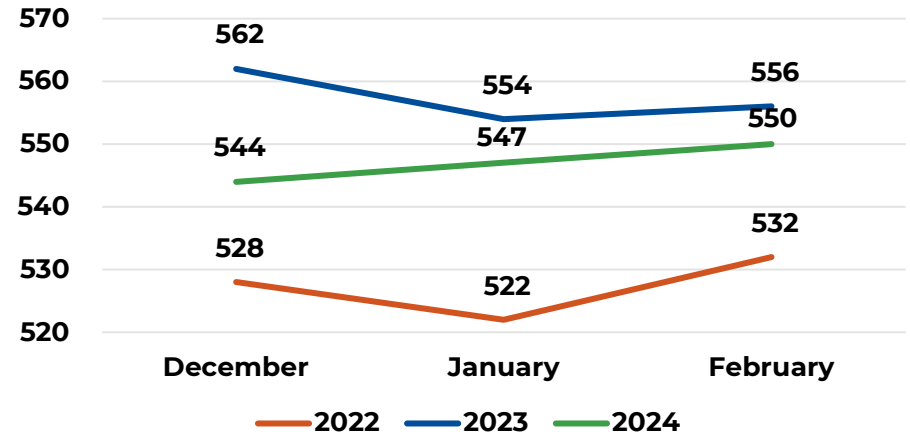
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

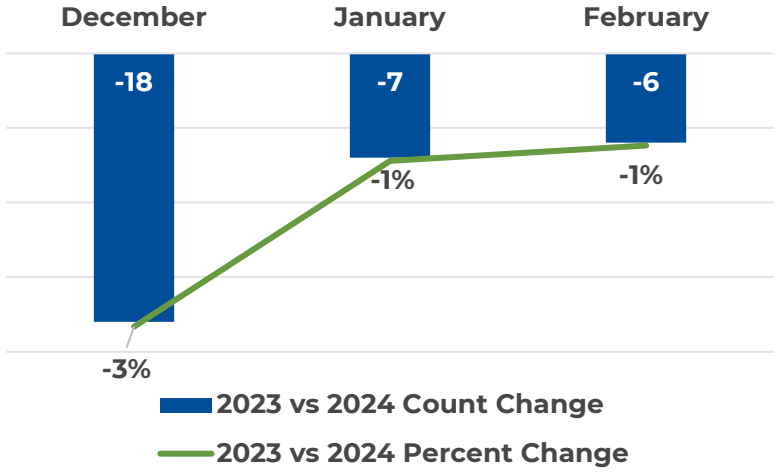




Agency Stats & Provider Network

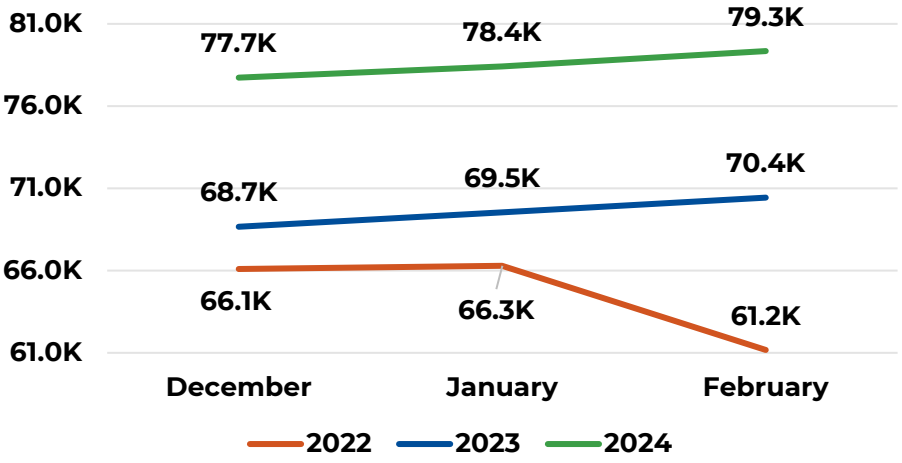
OHCA Admin - Number of FTEs

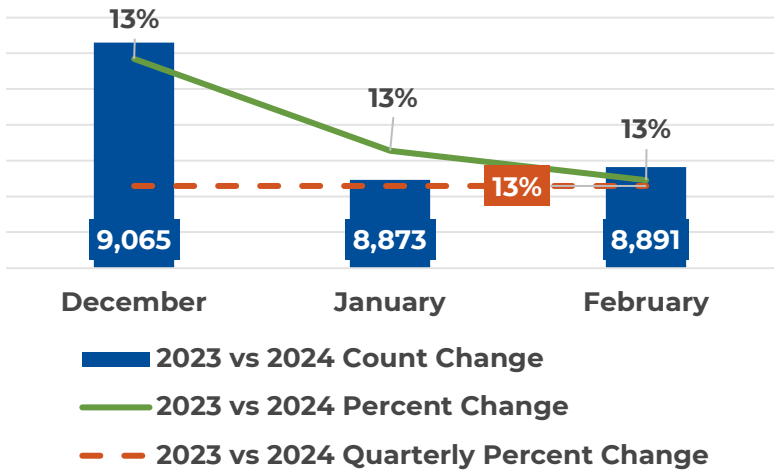




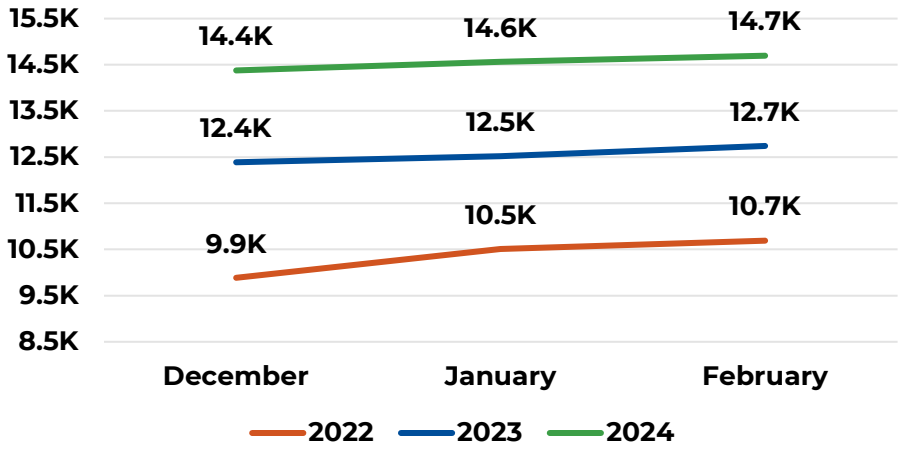
Agency Stats & Provider Network (Cont.)

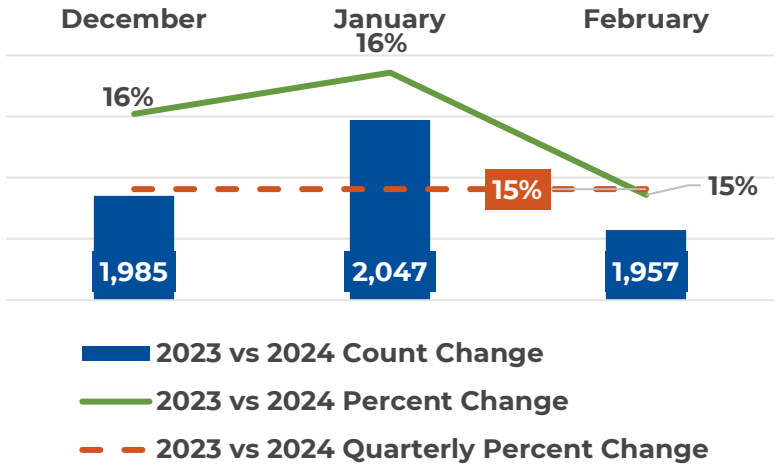
Total Providers





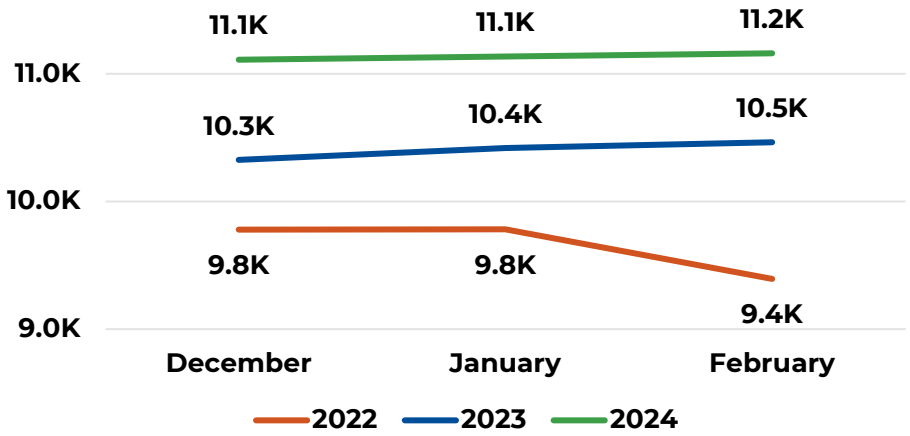
Mental Health Providers (In-State Only)

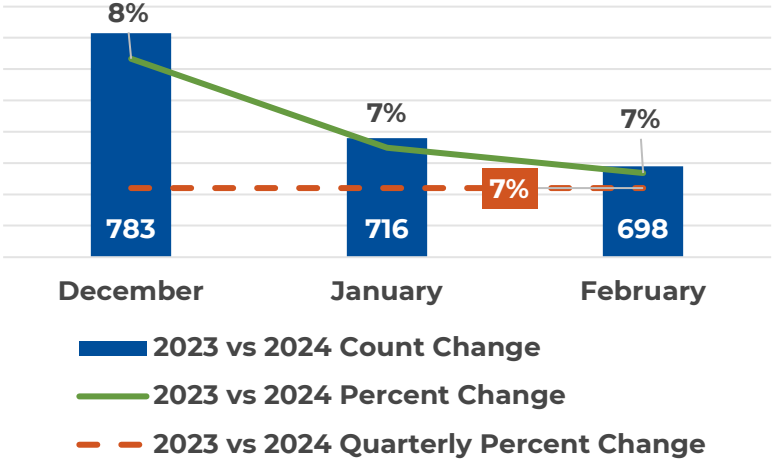




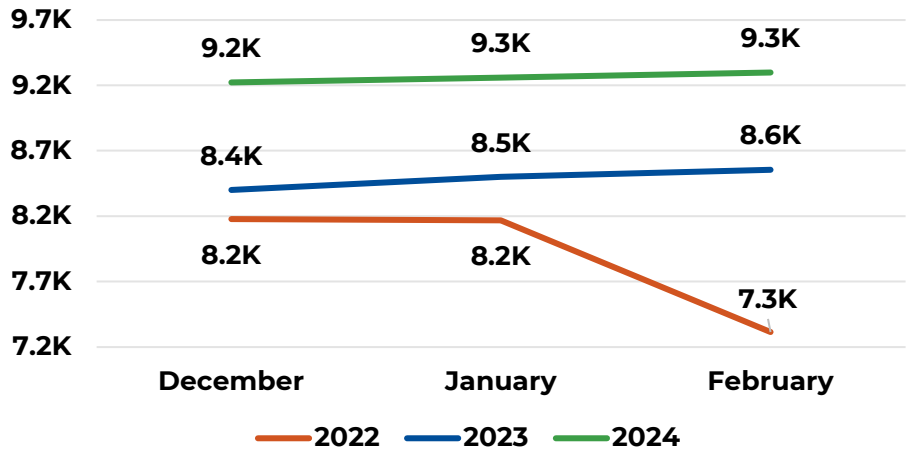
Agency Stats & Provider Network (Cont.)

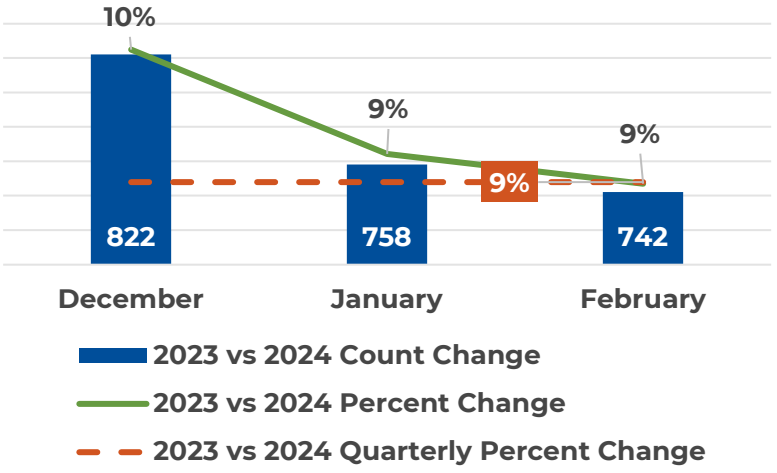
Physicians (In-State Only)





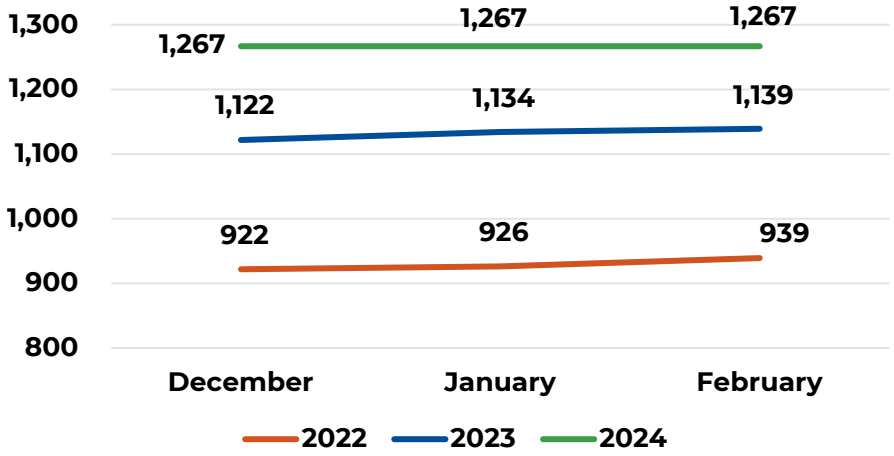
Primary Care Providers (In-State Only)

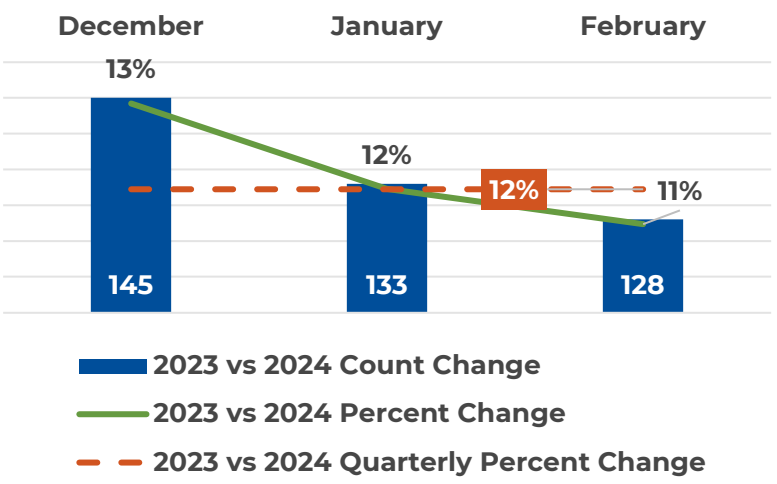




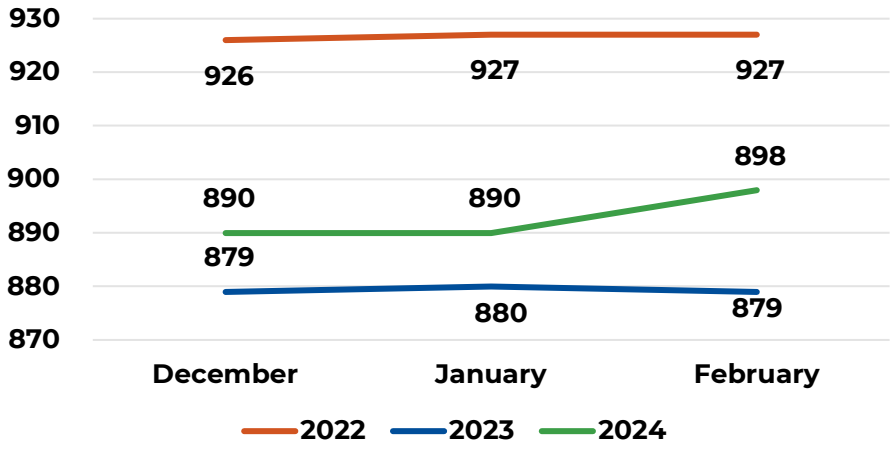
Agency Stats & Provider Network (Cont.)

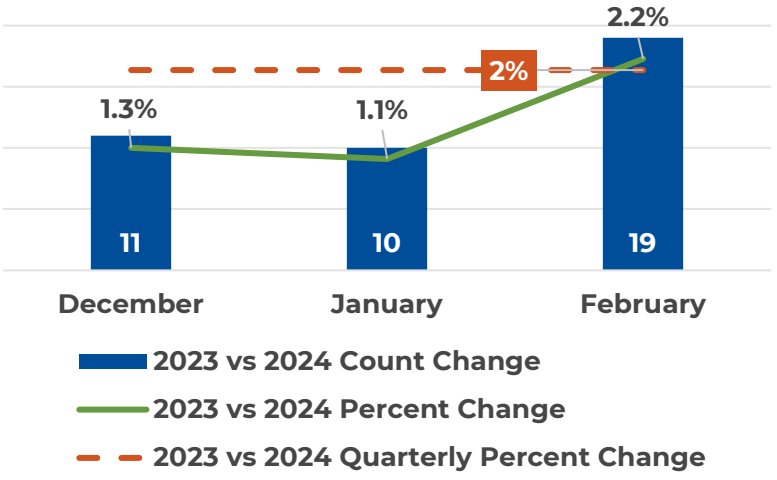
Dentists (In-State Only)





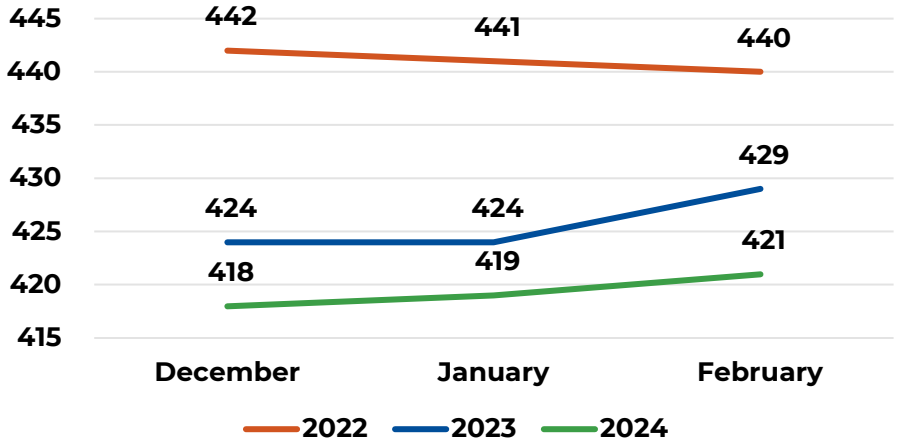
Pharmacy (In-State Only)

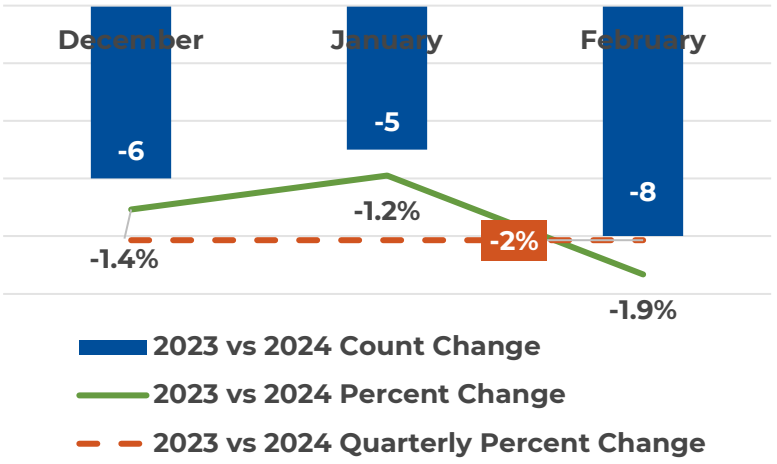




Agency Stats & Provider Network (Cont.)

Extended Care Facilities (In-State Only)





Hospitals (In-State Only)